

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM Alfred RAUGH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 5, 1984</b>		2b. HOUR <b>1:00PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 24 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>67</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital Corporation</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul N. Raugh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances A. Barnes</b>				13e. STREET ADDRESS <b>52 Kinship Road 21222</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-10-8153</b>		17. INFORMANT ADDRESS <b>Geraldine M. Raugh</b>		Same as 13e		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **ACUTE PULMONARY FAILURE**

4960

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **LEFT LOWER LOBE PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **BRONCHIECTASIS, EXTENSIVE PNEUMONIA RIGHT LUNG**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  
**TUBERCULOSIS LEFT LUNG; ANTEROLATERAL MYOCARDIAL ISCHEMIA; WEDGE RE-**

SECTION (XXXX)

19a. DATE OF OPERATION  
**MARCH 30, 1984**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**BRONCHIECTASIS (RIGHT LUNG)**

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **MARCH 9**, 19**84**, to **MAY 6**, 19**84**, that (I) (we) lost  
saw the deceased alive on **XX MAY 6**, 19**84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

*Sompalli Prasad*

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

**MAY 6, 1984**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**SOMPALLI PRASAD, MD.**

22e. ADDRESS

**CHURCH HOSPITAL CORPORATION,  
100 N. BROADWAY, BALTIMORE, MD. 21231**

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)  
**Burial**

23b. DATE

**5/9/1984**

23c. NAME OF CEMETERY OR CREMATORY

**Oak Lawn**

23d. LOCATION

**Baltimore**

COUNTY

STATE

**Maryland**24. FUNERAL DIRECTOR **Duda-Ruck, Inc.**

NAME

**7922 Wise Avenue**

ADDRESS

**Dundalk, MD. 21222**

25a. DATE REC'D. BY REGISTRAR

**MAY 8 1984**

25b. REGISTRAR'S SIGNATURE

*John Davidson-Randall*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Kil

A.

ie A. Barnes

ALLURE

A PNEUMONIA

ais, EXTENSIVE PNEUMONIA RIGHT LUNG

SECTION (XXX)

AROLATERAL MYOCARDIAL ISCHEMIA: WEDGE

ASIS (RIGHT LUNG)

X

MARCH 9  
84

MAY 6

OMPALLI PRAC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

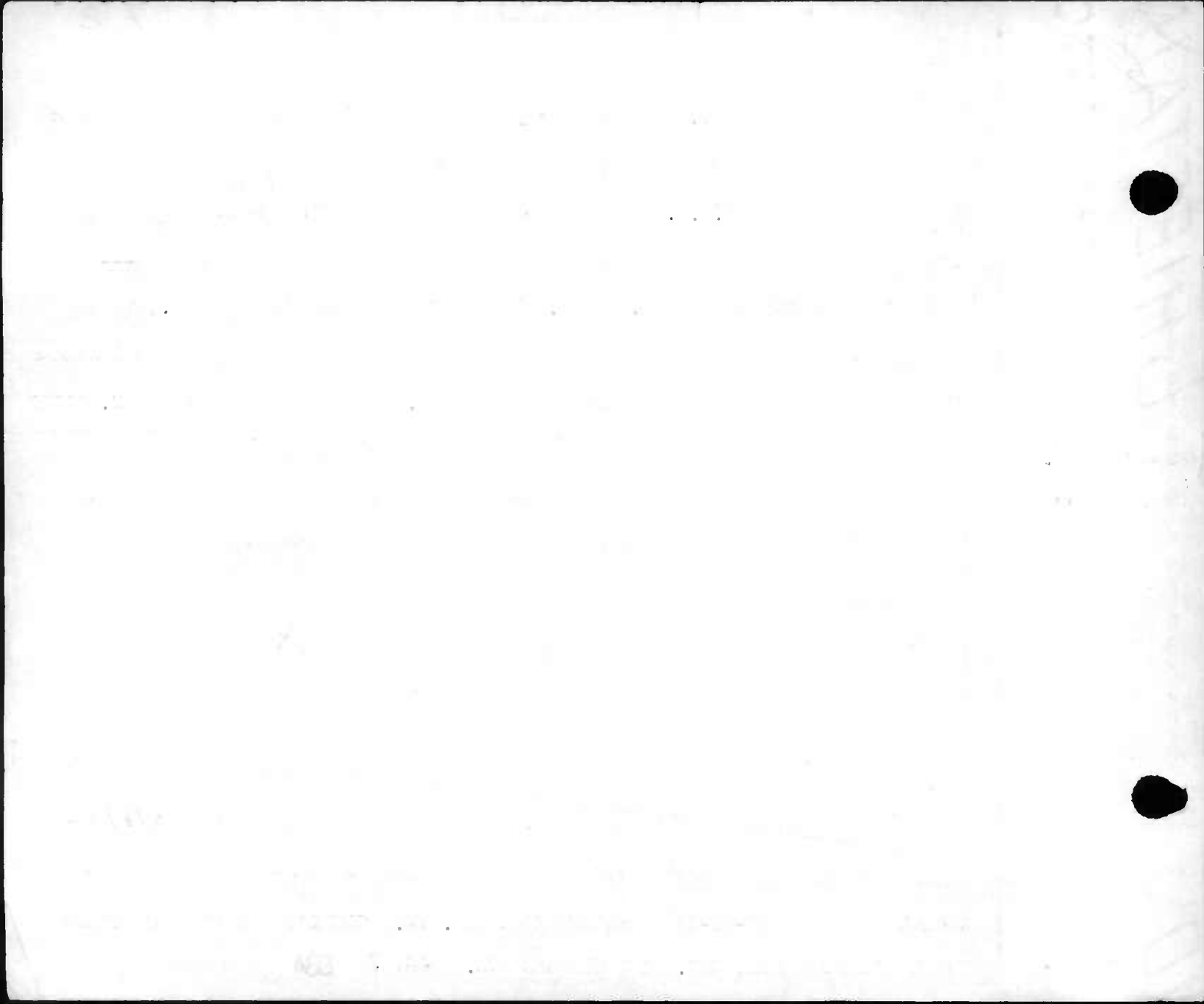
DHMH - 16 50M 4/B3  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL V. RAVEIO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/6/84</b>		2b. HOUR <b>2:40 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 09 1899</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>85</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN HOSP</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTO. HGLDS.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK KNAPP</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLA SHOEMAKER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-74-4215</b>		17. INFORMANT ADDRESS <b>VIRGINIA C. RAVEIO 4402 BALTIMORE ST. 21227</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>ACUTE MYOCARDIAL INFARCTION</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>5/6 (1:50 AM) 84</b> to <b>5/6 (2:40 AM) 84</b> , that (I) (we) last saw the deceased alive on <b>5/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Walter Lockhart, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5/6/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter Lockhart, MD</b>		22e. ADDRESS <b>5076 Balto Gen Hosp (300 S. Thacker St)</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>05-09-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELKRIDGE HOWARD MARYLAND</b>		23e. DATE REC'D. BY REGISTRAR <b>MAY 7 1984</b>				
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

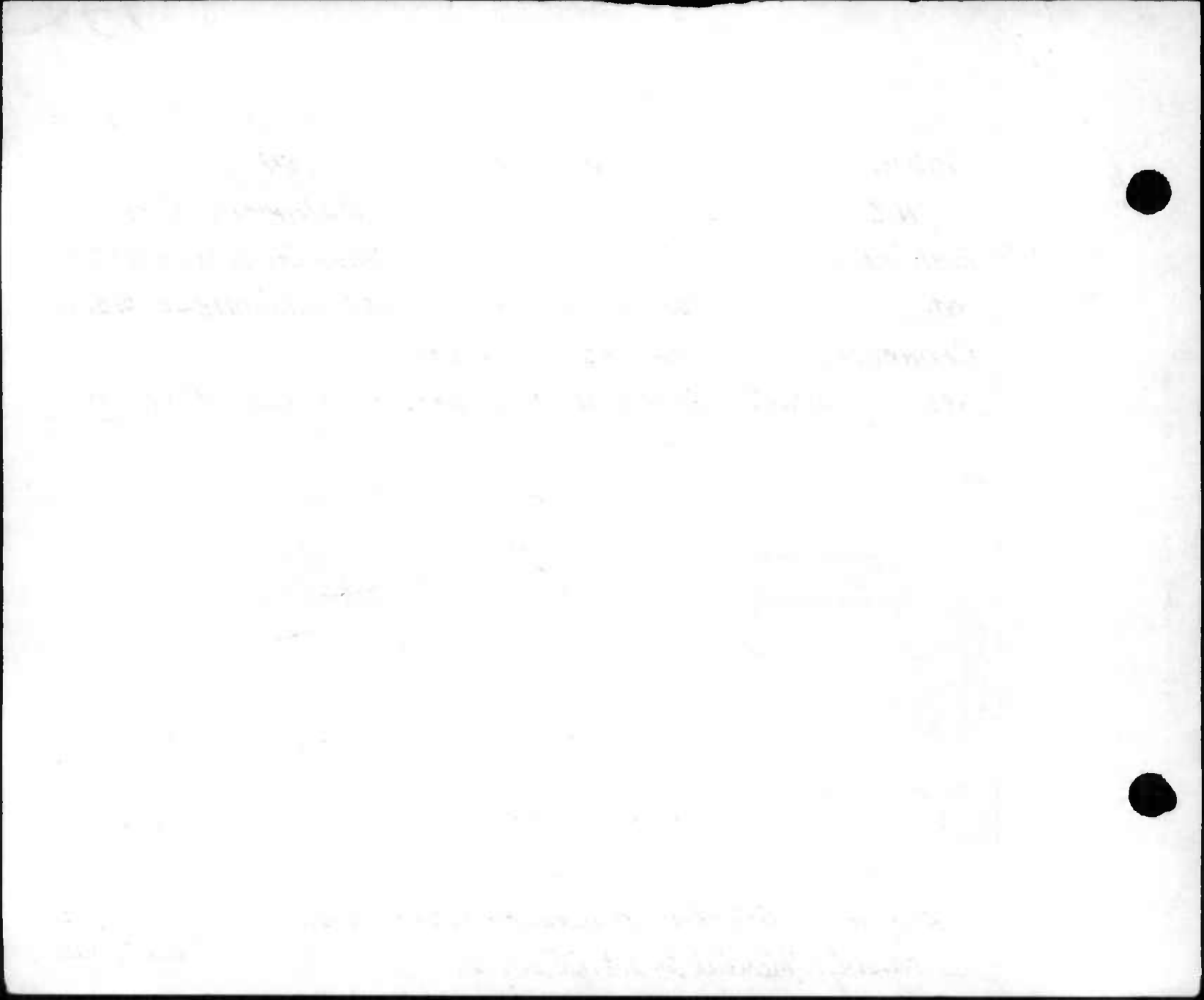
1. DECEASED NAME (TYPE OR PRINT) - Charles William Rawles			2a. DATE OF DEATH MONTH DAY YEAR 5-1-84			2b. HOUR 9 AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR JULY 25-1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shop Steward		12b. KIND OF BUSINESS OR INDUSTRY Steel Co.			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, /ZIP CODE 1532 E. Biddle St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Carnelious Rawles			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W.I			
16b. SOCIAL SECURITY NO. 216-0-5126			17. INFORMANT Katie Wood 1115 Northern Parkway						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal failure 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple myeloma DUE TO, OR AS A CONSEQUENCE OF (c) Peritonitis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cardiac arrhythmia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 4/27, 1984, to 5/1, 1984, that (I) (we) last saw the deceased alive on 4/30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Moses Coesrenan			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-7-84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD.		
24. FUNERAL DIRECTOR NAME Randolph J. Collick			ADDRESS 24316 Oliver St.			25a. DATE REC'D. BY REGISTRAR MAY 4 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Henry James Rayner</i>		2a. DATE OF DEATH MONTH <i>5</i> DAY <i>9</i> YEAR <i>1984</i>		2b. HOUR <i>7 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>3</i> DAY <i>25</i> YEAR <i>1914</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3610 Fait Avenue</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Baltimore</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>James</i> MIDDLE <i>Rayner</i> LAST <i>Rozella</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Sophia</i> MIDDLE <i>Fisher</i> LAST <i>Fisher</i>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>232-05-5325</i>		17. INFORMANT ADDRESS <i>Dorothy L. Rayner 3610 Fait Avenue 21224</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4275</i> IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest -</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Probable - Uncluttered lung ca.</i>					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/2/84</i> to <i>APRIL MAY 1984</i> , that (I) (we) lost saw the deceased <i>above</i> , (I) (we) (did/did not) view the body after death, and that it is (my/our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <i>Arthur Friedman MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/9/84</i>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur Friedman MD</i>		22c. ADDRESS <i>Dept of medicine Balt City H3/p2</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-12-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>		ADDRESS <i>901 S. Conkling St.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 10 1984</i>	
				REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodella</i>	

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JENNIE S. Reamer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 28 84</b>		2b. HOUR <b>7:35pm</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 22 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO, MD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AYMAN XX Schwartz</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>XXXXXX XXXX Meyer</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
17. INFORMANT <b>MRS. IRMA R. JACOBS</b>		18. SOCIAL SECURITY NO. <b>2171-6-1464</b>			
19. ADDRESS <b>7412 PRINCE GEORGE RD. BALTO., MD 21208</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

7991 IMMEDIATE CAUSE (a) **Respiratory Failure**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**Chronic renal failure, Mitral insufficiency, Hemorrhage**

19a. DATE OF OPERATION <b>5-23-84</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **5/22** 19 **84**, to **5/28** 19 **84**, that (I) (we) last saw the deceased alive on **5/28** 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE <b>Donna St. Martin</b>	22b. ADDRESS <b>Mary Hospital</b>	22c. DATE SIGNED <b>5/28/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donna St. Martin</b>	22e. ADDRESS <b>Mary Hospital</b>	22f. DATE SIGNED <b>5/28/84</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>MAY 29, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>	23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 31 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>Sol Levinson</b>		26. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

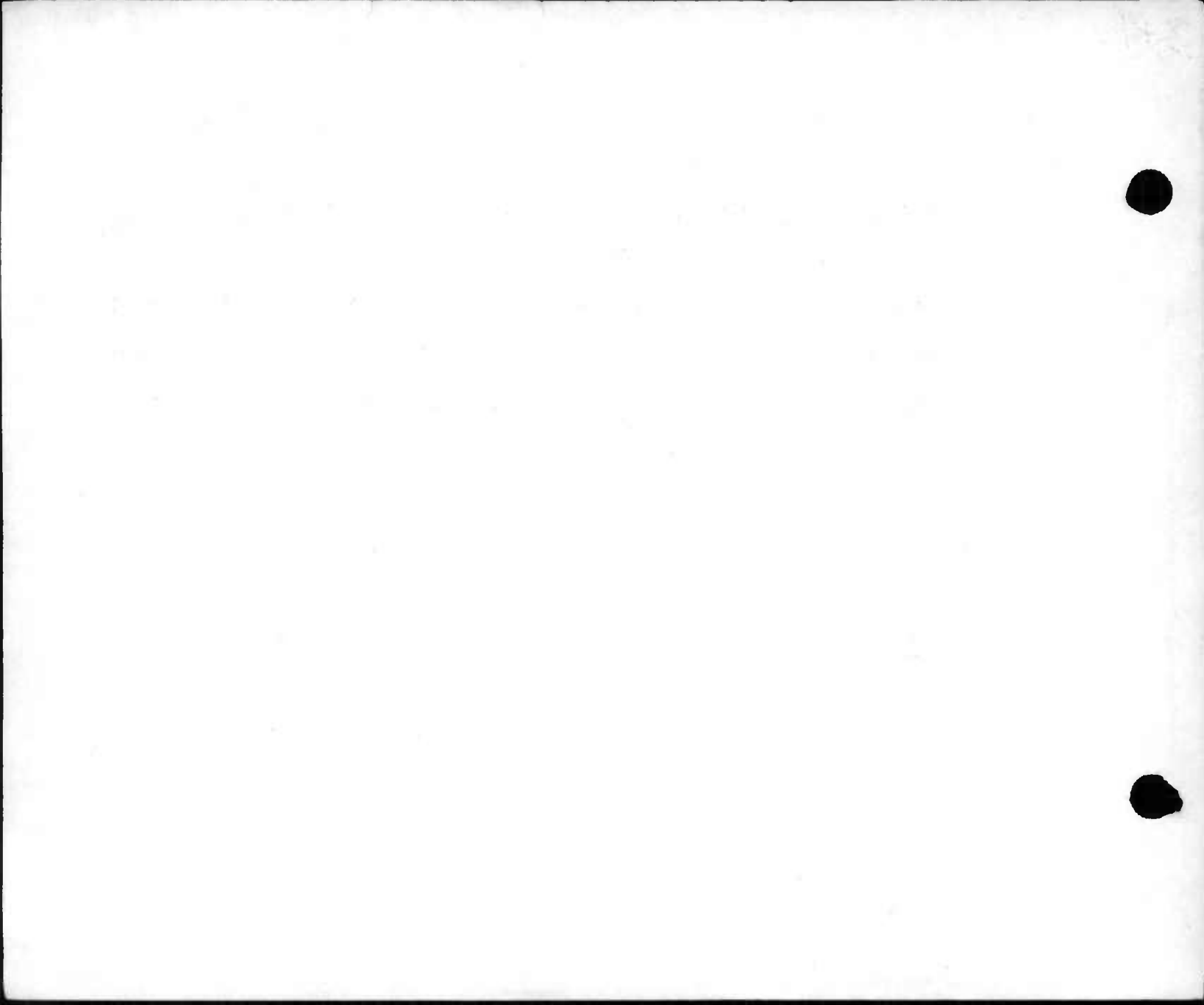
IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
MCKINLEY		Male		Black	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
MONTH DAY YEAR 4 11 96		89 YRS.		BALTIMORE CITY MD	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Virginia		U.S.A.		VA MEDICAL CENTER BALTO MD	
11. CITY OR TOWN OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST Housin Redd		FIRST MIDDLE LAST Mittie Rowe		1017 N. Wolfe St. 21205	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES		213 07 0608		Ella Redd 1017 N. Wolfe Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA (Klebsiella pneumoniae) septic</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9/20 DUE TO, OR AS A CONSEQUENCE OF					19 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASPIRATION</u>					2 1/2 days
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Odontoid Fracture, H.A.L.O. Cervical</u>					60 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ACUTE Renal Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
NONE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MAY 23</u> , 19 <u>84</u> , to <u>MAY 29</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>MAY 29</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
<u>L.J. Eglseder III MD</u>				5/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
<u>L.J. Eglseder III MD</u>				<u>Lock Raven Veterans Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		6/4/84		Garrison Forest VA	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		MAY 31 1984		<u>Julia Davidson-Randall</u>	
Wm C March F/H Inc. 1101 E North Avenue					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL REED</b>			2a. DATE OF DEATH MONTH <b>05</b> DAY <b>03</b> YEAR <b>84</b>		2b. HOUR <b>800 P.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>05</b> DAY <b>03</b> YEAR <b>84</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN <b>40</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>
13a. STATE <b>Md</b>			13b. CITY OR TOWN <b>Balto</b>	13c. STREET ADDRESS / ZIP CODE <b>2609 Fairview Ave. 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N.O.</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY, Severe</b> 7650 DUE TO, OR AS A CONSEQUENCE OF (b) <b>PREMATURITY, Severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>PREMATURITY</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>—</b>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7:00 PM 05/03 19 84</b> to <b>8:00 PM 05/03 19 84</b> , that (I) (we) saw the deceased alive on <b>8:00 PM 05/03 19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. Balderrama</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>05/03/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. BALDERRAMA</b>		22e. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>5/10/84</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Felia Davidson-Randall</b>			

MEDICAL CERTIFICATION

35  
38  
35  
300  
1  
9  
9  
1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

SYLVIA ELIZABETH REED

2a. DATE OF DEATH

MONTH

DAY

YEAR

MAY 5 31 84

2b. HOUR

M

3. SEX

FEMALE

4. RACE

NEGRO

5. DATE OF BIRTH

MONTH

DAY

YEAR

6 18 1913

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

71

MONTHS

DAYS

HOURS

MIN.

YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

KALIEGH N.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE

MD.

10. CITY OR TOWN OF DEATH

BALTO.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

3104 E. FEDERAL ST

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

M.D.

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☒NO ☐

13e. STREET ADDRESS

3104 FEDERAL ST

14. FATHER'S NAME

FIRST

MIDDLE

LAST

John Thomas YARBOROUGH

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Catherine BARNARD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

217-20-8656

17. INFORMANT

ADDRESS

Charles E YARBOROUGH 1224 CAROLINE ST

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a):

Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(b):

ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

Year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 1970, 19, to present, 19, that (I) (we) lost saw the deceased alive on 5/1, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

John Mann MD

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

6/4/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MANN JOHN J

22e. ADDRESS

611 PRAIRIE AVE BALT 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

6-6-1984

23c. NAME OF CEMETERY OR CREMATORY

ARBITUS MEM PARK

23d. LOCATION

ARBITUS

COUNTY

M.D. STATE

24. FUNERAL DIRECTOR

NAME

Rede Funeral Home 5200 York Rd

ADDRESS

25a. DATE REC'D. BY REGISTRAR

JUN 4 1984

25b. REGISTRAR'S SIGNATURE

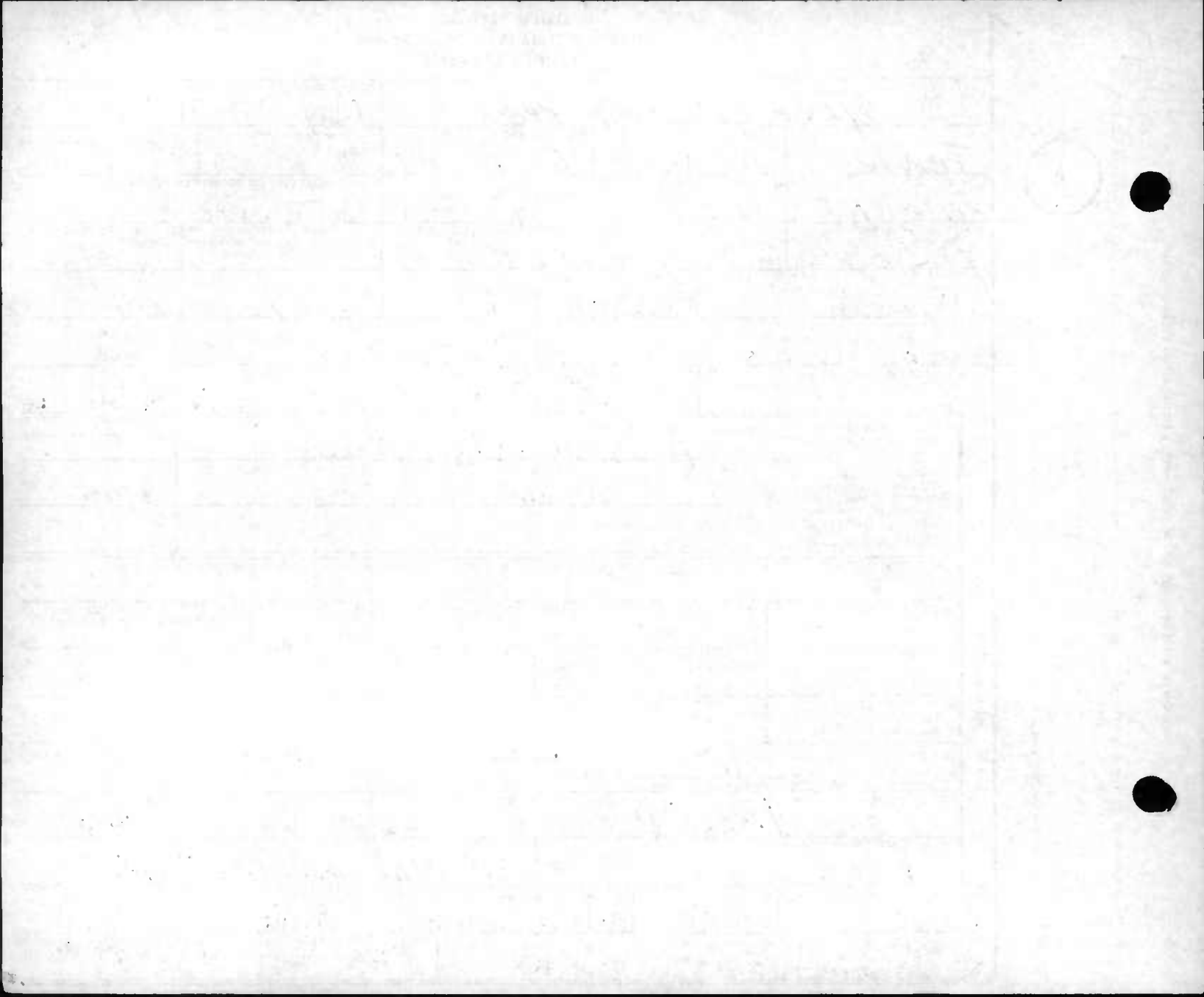
John Mann

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Minnie J. Reineker		female		white	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
9 14 1889		94 YRS.		Baltimore City MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		cook		Domestic	
10. BIRTHPLACE (STATE OR FOREIGN)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS	
Maryland		Lutheran Hospital		2601 Wegworth Lane 21230	
13b. STATE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS	
Md.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Christian F. Houch		Florence Heinz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		.220 30 7488		Karl Reinsfelder (same as 13E)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
4280 IMMEDIATE CAUSE (a) Congestive Heart Failure					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/19/84 to 5/25/84, that (I) (we) last saw the deceased alive on 5/23/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
MARC DAVIS				5/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MARC DAVIS		907 BAY NAT PILE EC MD		21013	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		5/29/84		Cedar Hill Cemetery Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George J. Gonce Baltimore Md. 21225		MAY 29 1984		John Davidson-Randall	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Rosetta Q. Reynolds</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5 28 84</b>		2b. HOUR <b>9:35</b> A.M.	
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 25 184</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66 69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. STREET ADDRESS / ZIP CODE <b>709 N Carey St 21217</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Reynolds</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Locks</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>4150 Smith St Furman Pl</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1579</b> IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with metastases to liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with liver failure</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>month</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. OSEI-WUSU MD</b>				22e. ADDRESS <b>Bon Secours Hospital, BALT. MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-1-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROOKS CHAPEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Calvert Co., MD</b>	
24. FUNERAL DIRECTOR NAME <b>Manfred P. Hays</b> ADDRESS <b>6387 71st Ave</b>				25. DATE REC'D. BY REGISTRAR <b>JUN 4 1984</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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4

1. The first part of the paper is devoted to a general  
discussion of the problem. It is shown that the  
problem is of great importance and that it has  
not been completely solved. The author then  
presents a new method for solving the problem.  
This method is based on the use of the  
Fourier transform. It is shown that this  
method is very effective and that it can be  
applied to a wide range of problems.  
The author then discusses the results of his  
calculations. It is shown that the results are  
in good agreement with the experimental data.  
The author concludes that the new method is  
very effective and that it can be applied to  
a wide range of problems.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

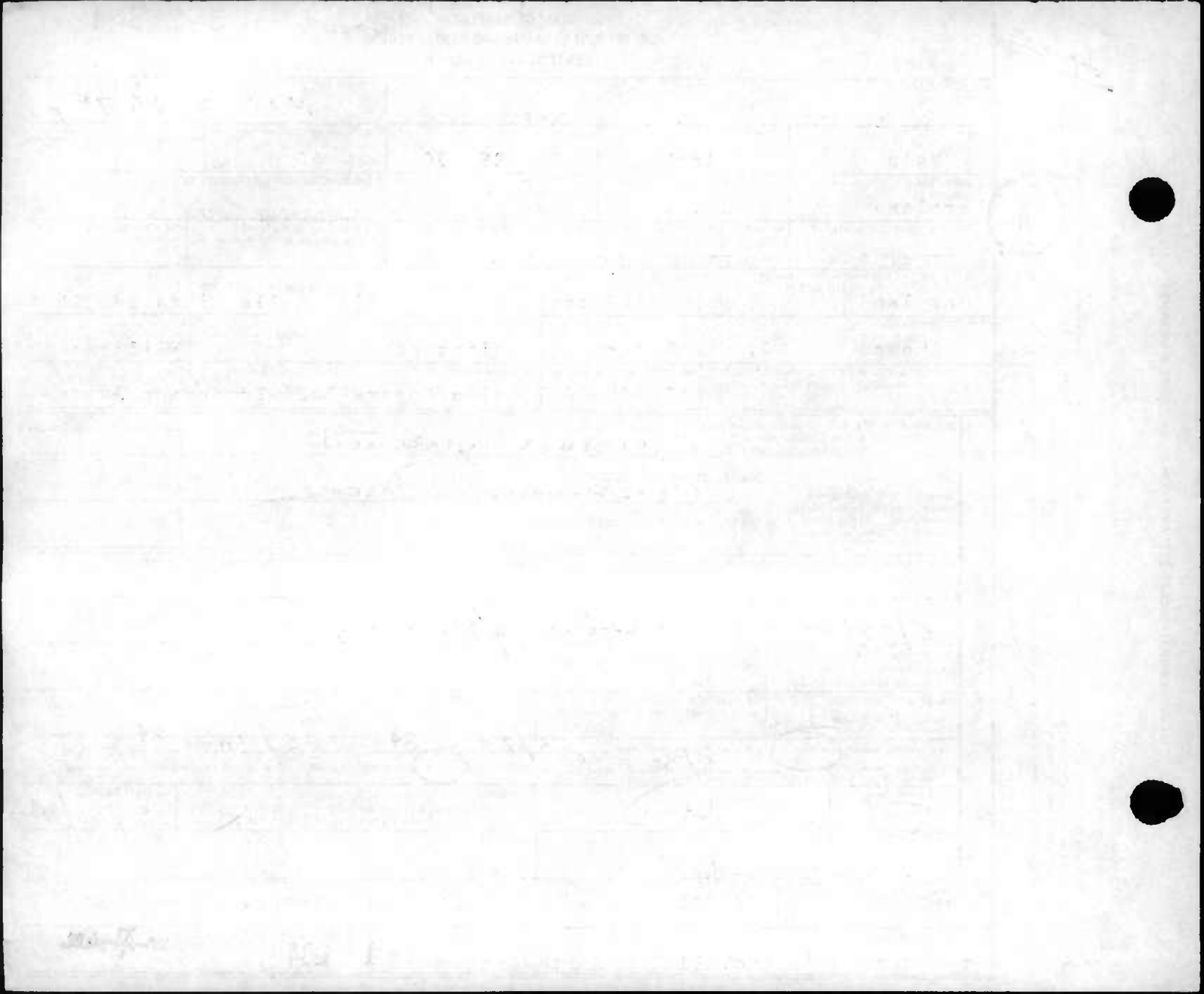
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES W. ROGERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 30 84</b>		2b. HOUR <b>7<sup>35</sup> P.M.</b>						
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 28 36</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS / ZIP CODE <b>5443 Belle Vista Rd. 21206</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas J. Rogers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Williams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-32-9687</b>		17. INFORMANT ADDRESS <b>Nelda Rogers 3425 Edmondson Avenue</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3484</b> IMMEDIATE CAUSE (a) <b>CEREBELLAR INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBROVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <b>5/29/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CEREBELLAR SWELLING/HERNIATION</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5/29 1984</b> to <b>5/30 1984</b> , that (I) (we) last saw the deceased <b>above</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>SCOTT L. LUTTGE M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/30/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOTT L. LUTTGE M.D.</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>6/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 1 1984</b>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 2 3 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Arthur N. Reid Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 4 1984</i>			2b. HOURS <i>(Home) 5:45 PM</i>			
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 10, 1937</i>		6. AGE (IN YEARS, LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>46 yrs.</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (CITY, STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY <i>—</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY, GIVE STREET ADDRESS) <i>3705 Everett St.</i>				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		13. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE <i>MD.</i> 14b. COUNTY <i>Baltimore</i> 14c. CITY OR TOWN <i>Baltimore</i>			15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16. STREET ADDRESS ZIP CODE <i>3705 Everett St. 21335</i>				
17. FATHER'S NAME (FIRST, MIDDLE, LAST) <i>William Reid</i>			18. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) <i>Margaret Ellen</i>			19. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR SERVICE) <i>Yes, Du-Fac 330-203458, Vietnam 3705 Everett St.</i>			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <i>4/5/84</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles A. Patalunga</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/4/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. N. PATALUNGAS</i>			22e. ADDRESS <i>803 E. PATAPSCO AVE BALTIMORE</i>			22f. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore 21205</i>			
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>			23b. DATE <i>5/5/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview M. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore 21205</i>		
24. FUNERAL DIRECTOR <i>Charles A. Patalunga</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 7 1984</i>			25b. REGISTRAR'S SIGNATURE <i>John A. Patalunga</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1900  
JAN 10

1900

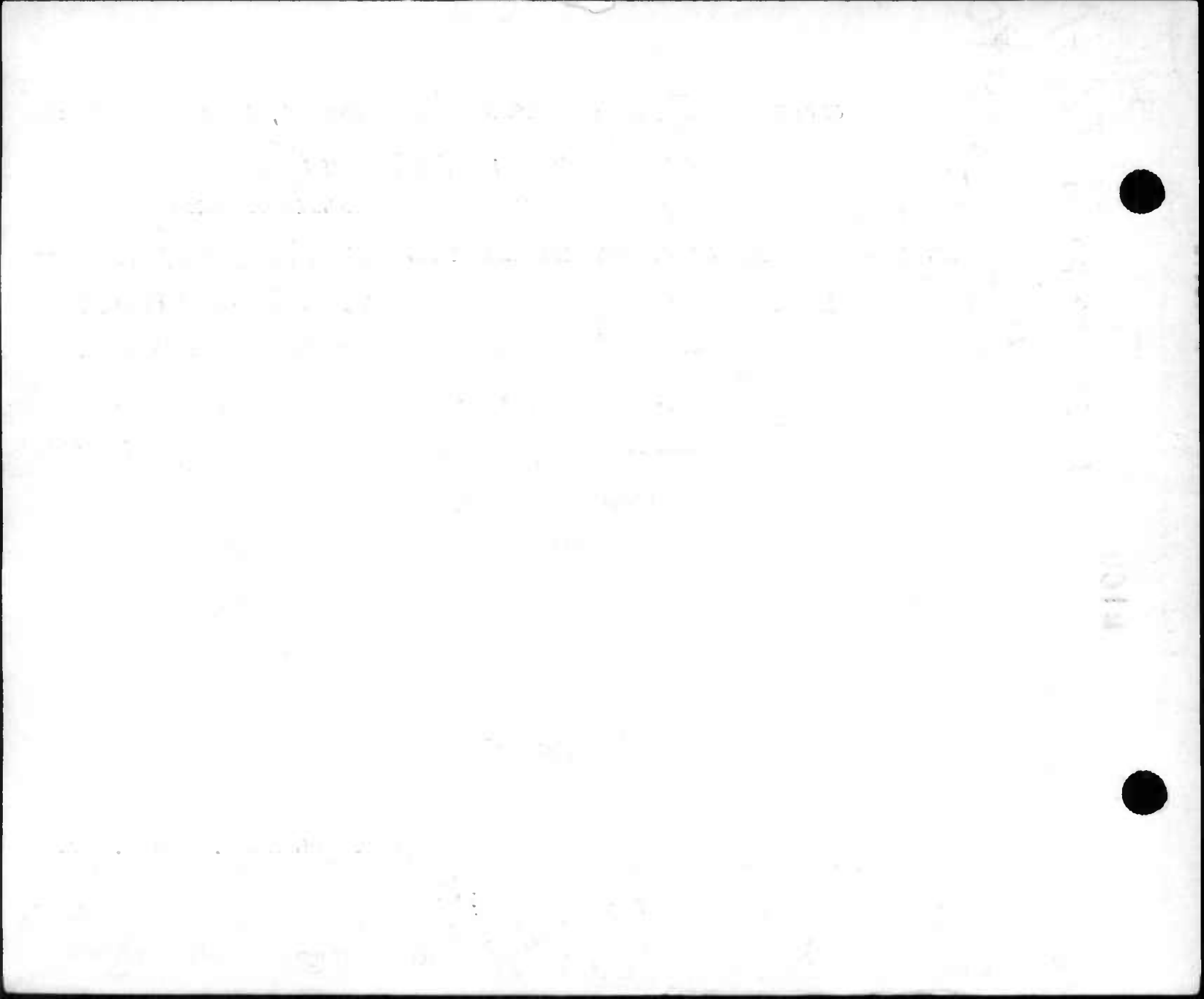
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 2 8 3

FOR  
1- STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>JESSIE James REID Sr.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>MAY 16, 1984</b>		2b HOUR <b>11:18</b>	
1 SEX <b>Male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>3 1 1939</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) <b>Alabama</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Cement</b>	
13a STATE <b>Fla.</b>	13b COUNTY <b>Lee</b>	13c CITY OR TOWN <b>Pt. Meyers</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>3228 South St. 99999</b>	
14 OTHER'S NAME FIRST MIDDLE LAST <b>Roosevelt Reid Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Bella Moore</b>		ADDRESS <b>Pt. Meyers Fl.</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>418-46-9643</b>		17 INFORMANT <b>Mr. Finky Carter</b> ADDRESS <b>3696 Anderson Ave. Fla.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>1550</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2315-2318 pm</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>5/16/84</b> , 19 <b>84</b> to <b>5/16</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>James E. Greenwald</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>5/16/84</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES E. GREENWALD</b>		22e ADDRESS <b>600 N. WOLFE ST. BALTO. MD. 21205</b>				
23a BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b DATE <b>5-23-84</b>		23c NAME OF CEMETERY OR CREMATORY <b>Pt. Meyers Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Lee Florida</b>
24 FUNERAL DIRECTOR NAME <b>Carlton C. Douglas</b>		ADDRESS <b>1012 Penn Ave.</b>		25a DATE REC'D. BY REGISTRAR <b>MAY 18 1984</b>		25b REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 3 2 8 4

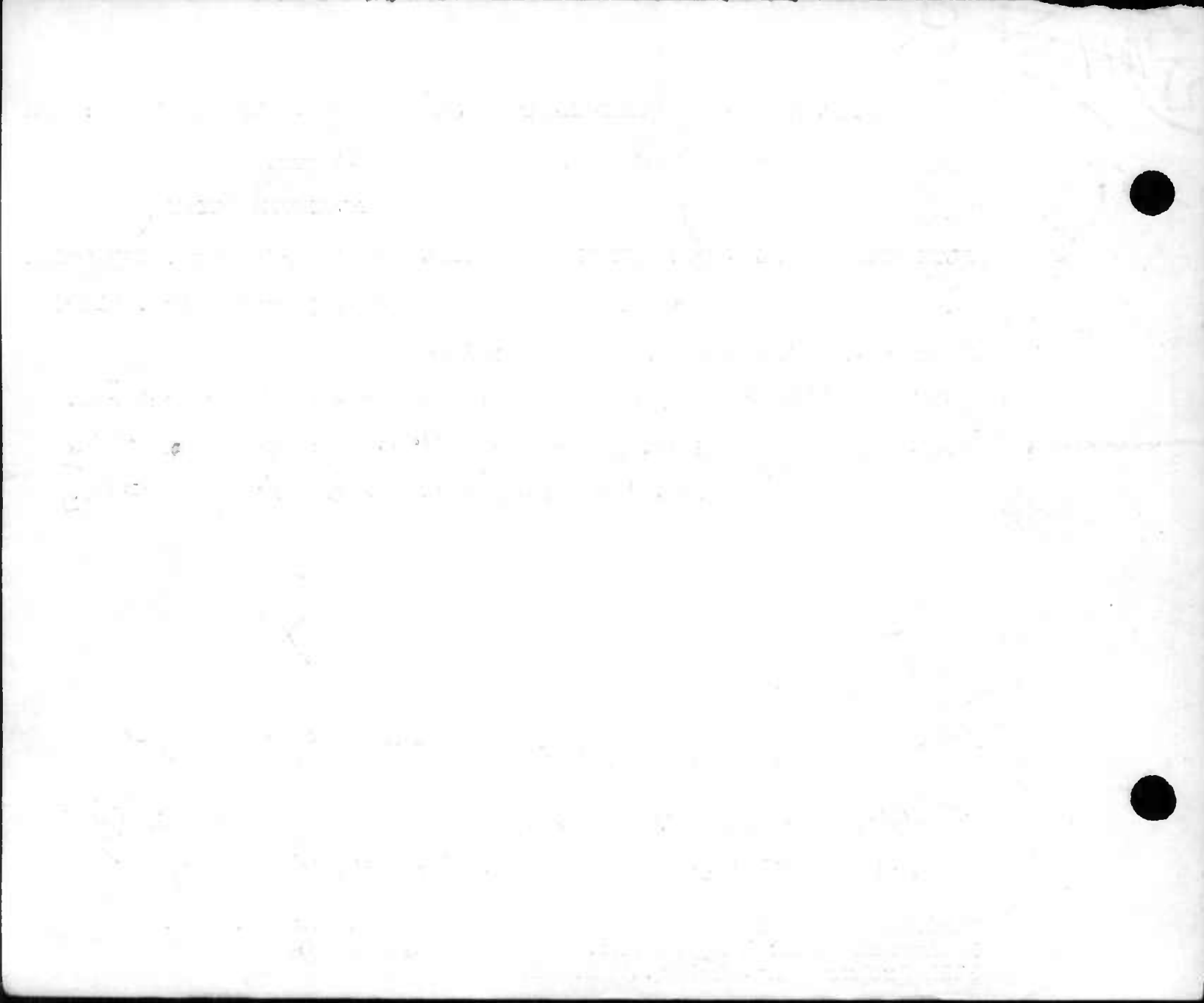
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		05 05 84		5:00PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		8-11-43		40 yrs.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		USA				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Engineering Ass.		C&P Tele.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Charles B. Reinhardt Sr.		Caroline Adams		yes		214-44-6378	
17. INFORMANT		ADDRESS		21206		21206	
Joan Reinhardt		6407 Rosemont Ave.		21206		21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)	
4300		Intracerebral Hemorrhage.		Probable Ruptured cerebral Artery.		6 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						6 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		19 4/29		to 19 5/5		that (I) (we) last saw the deceased alive on 5/5/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Moffatt		MD				3/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Moffatt		Johns Hopkins Hospital.		Burial		5-9-84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR WITH REGISTRATION NO.		23f. SIGNATURE	
Gardens of Faith Cem.		Balto., Md.		MAY 8 1984		Johns Hopkins	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR WITH REGISTRATION NO.		25b. SIGNATURE			
Schamunek Funeral Home, Inc.		MAY 8 1984		Johns Hopkins			
3331 Brehms Lane, Balto., Md. 21213							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.


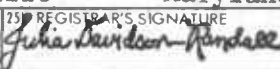
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1- For further phone call to F.H. DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR 5/4/84 rja  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Glenn E. Remmells</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5/2/84 19</b>		2b. HOUR <b>8:31 P</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 29 1929</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>54 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Remmells</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leone Riley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 217-26-9394</b>		17. INFORMANT ADDRESS <b>Mary L. Remmells 3514 Ellerslie Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Assistant</b>		DATE SIGNED <b>5/13/84</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 7, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veterans Pikesville Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1984</b>		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

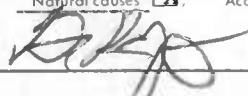

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 2 AND 3 TO THE FURNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 8. RETAIN PAGE 4 FOR YOUR FILES. TO FURNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Mary WELSH Respass</b>						7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5/12/84</b>		7b. HOUR M <b>4:06</b> P <b>M</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5/12/84</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>42</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>5/12/84</b>		7d. HOUR M <b>4:06</b> P <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4315 Marble Hall Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>4315 Marble Hall Rd 21218</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Joseph Welsh Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Tracey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-22-9748</b>		17. INFORMANT ADDRESS <b>Richardson, TX 75080</b> <b>Mrs. M.L. Losby 2421 Canyon Creek Dr.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>5/13/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-16-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1984</b>		25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Edwin Major Reynolds				May 2, 1984 10:00P <sub>M</sub>			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1909		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 St. George's Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Relations-Advertising		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Hardcastle Reynolds		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Major		13e. STREET ADDRESS / ZIP CODE 700 St. George's Road 21210			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Edwin M. Reynolds, Jr. 3934 Cloverhill Rd. Bal. Md.		21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Hypernephroma</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>84</u> to <u>May 2</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dain M. Hahn</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Davis M. Hahn				22e. ADDRESS 5601 Loch Raven Blvd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 3, 1984		23c. NAME OF CEMETERY OR CREMATORY St. Davids Ch. Cem. Greenmount Crematory		23d. LOCATION Radnor Co. Pa. Baltimore City Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				25a. DATE REGD. BY REGISTRAR MAY 7 1984		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>	

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Creation of the National Security Council Intelligence Directive (NSC-5412) in 1954, which established the NSAS as the primary agency for the collection and analysis of intelligence on the Soviet Union, China, and the Eastern Bloc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Jervey Rich</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5-18-84</b>		2b. HOUR M	
3. SEX <b>male</b>		4. RACE <b>Col</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-22-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1127 Ellicott Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13e. STREET ADDRESS / ZIP CODE <b>1127 Ellicott Drive 21216</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Abraham Rich</b>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Erene Green</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16a. SOCIAL SECURITY NO. <b>213-07-4010</b>		17. INFORMANT <b>Mrs. Lillian Rich</b>		ADDRESS <b>1127 Ellicott Drive 21216</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>5050</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC LUNG DISEASE.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMOCOCCIOSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 27</b> , 19 <b>84</b> , to <b>APRIL 27</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>APRIL 27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Oscar Abosch</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-23-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Oscar Abosch, M.D.</b>				22e. ADDRESS <b>122 Slade Avenue, Baltimore, MD 21208</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5-23-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>				ADDRESS <b>2222 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 24 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>L. Davidson-Randall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "x", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST <i>Mary Rinker</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>May 4 1984</i>				2b. HOUR M <i>M</i>	
3. SEX <i>F.</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11/25</i>		6. AGE (IN YEARS AND BIRTHDAY) YEARS MONTHS DAYS <i>59y.</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>59y.</i>		8. IF UNDER 24 HRS. HOURS MIN. <i>59y.</i>	
9. PLACE (STATE OR FOREIGN) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1472 Woodall St.</i>				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY <i>Md. Baltimore</i>						13c. CITY OR TOWN <i>Balt.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1472 Woodall St 21230</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Kirkbrear</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Julia Kirkbrear</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN, "X") (IF YES, GIVE WAR OR DATES) <i>No.</i>						16b. SOCIAL SECURITY NO. <i>193-182336</i>		17. INFORMANT NAME ADDRESS <i>Robert Rinker 1472 Woodall St 21230</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Cervix with metastases</i> 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN (a) AND (b) <i>4 years</i>										APPROXIMATE INTERVAL BETWEEN (a) AND (b) <i>4 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>4-25-1984</i> to <i>5-4-1984</i> , that (2) (we) last saw the deceased alive on <i>5-3-1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alfred J. Daniels MD</i>						DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/5/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfred J. Daniels MD</i>						22e. ADDRESS <i>519 E. Fort Ave. Baltimore Md 21230</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>5/8/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Vernon</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Baltimore Md</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Charles L. Sterner Funeral Home Inc. 715 D St. Baltimore</i>						25. DATE REC'D. BY REGISTRAR <i>MAY 7 1984</i>		26. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

BP \_\_\_\_\_

10BET

9

Handwritten notes at the bottom of the page, including the word "AX" and "P. YAN".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1 3 2 9 0	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NUNZIATO RIZZI						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-21-84 <sub>19</sub>		2b. HOUR M 8:14A			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 25, 1892		6. AGE (IN YEARS) LAST BIRTHDAY 91RS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4100 Ardley Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Laborer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4100 Ardley Ave. 21213		
14. FATHER'S NAME FIRST MIDDLE LAST Rocco RIZZI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aurelia ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-12-6039A		17. INFORMANT Nicholas A RIZZI, 2213 Inglewood Ave. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 5-22-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/24/84		23c. NAME OF CEMETERY OR CREMATORY Holy REDEEMER Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc						ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR MAY 24 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

DECLASSIFIED

NOV 19 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
VIRGINIA		E.		ROBBINS				5 9 84		6:30 P	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		10 6 02		81 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
N. Dakota		U.S.A.				Balto. City MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Balto.		1022 Jacks Place				Nurse		Private Duty			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Md.				Balto.				1022 Jacks Place		21225	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No				216-22-4276		Mr. Thomas Robbins		1630 Popland St. Balto., Md. 21226			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) cardio-Pulmonary arrest											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Heart failure											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 7/22 19 83, to 11/17 19 83, that (I) (we) last saw the deceased alive on 11/17 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
Mr. Welinsky				M.D.				5/21/84			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
Melvin Welinsky				Bank Street				21224			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Removal		5/9/84									
24 FUNERAL DIRECTOR NAME						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Anatomy Board						JUN 5 1984		P. Davidson-Randall			
ADDRESS						Balto., Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the Store Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the Store Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

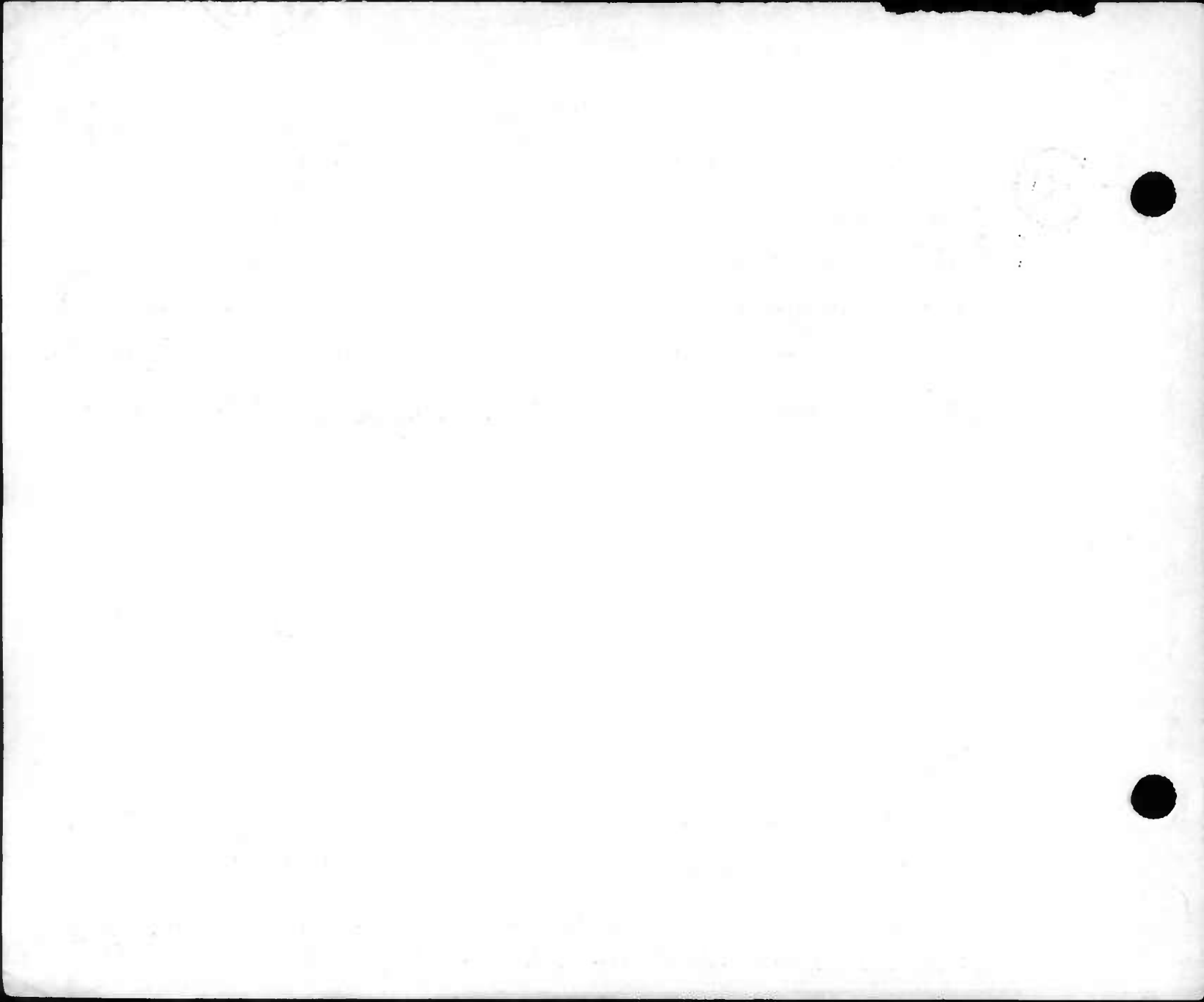
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR #5,6, per F.H.5/8/84 kdm  
STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John F. Roberts</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>6</b> YEAR <b>84</b> 2b. HOUR <b>1:35</b> A.M.		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>9</b> YEAR <b>1929</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS. <b>54</b> MONTHS <b>5</b> DAYS <b>13</b> HOURS <b>5</b> MIN.		7. IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>13</b> HOURS <b>5</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. STREET ADDRESS / ZIP CODE		
13a. STATE <b>MD.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>416 S. Polaski St. 21223</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>F</b> LAST <b>Roberts</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ruth</b> MIDDLE <b>Rigley</b> LAST <b>Spindlen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>217-26-3935</b>		17. INFORMANT <b>Mrs. Shirley Roberts</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG WITH</b> DUE TO, OR AS A CONSEQUENCE OF <b>CNS METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>D. Shamsuddin</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. SHAMSUDDIN</b>		22e. ADDRESS <b>Bon Secours Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Maryland</b>		25. DATE RECEIVED BY REGISTRAR 75% REGISTRAR SIGNATURE <b>MAY 7 1984</b>			
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home 1328 Sulphur Spring Rd.</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 7 should be detached for use as the burial/transit permit). Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who is notified of death must complete a separate report.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RACHEL W ROBERTS			2a. DATE OF DEATH MONTH DAY YEAR 5 31 84			2b. HOUR 7:29 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/24/15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CITY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSEW		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.			13b. COUNTY BALTO		13c. CITY OR TOWN MIDDLE RIVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HARRY E. WILSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVIA R. BOHR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218225594		17. INFORMANT DUKE HARRISON			ADDRESS 7523 DOBWOOD RD	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO, OR AS A CONSEQUENCE OF BRADYCARDIC episode	
		(c) DUE TO, OR AS A CONSEQUENCE OF END-STAGE ischemic CARDIOMYOPATHY	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/16, 19 84, to 5/31, 19 84, that (I) (we) last saw the deceased alive on 5/31, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joel Berezow		DEGREE	
22c. DATE SIGNED 5/31/84		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL BEREZOW		22e. ADDRESS c/o BCH 4940 Eastern AVE BALTO, MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/4/84		23c. NAME OF CEMETERY OR CREMATORY PROSPECT CEM		23d. LOCATION CITY OR TOWN COUNTY STATE MT. AIRY MD.	
24. FUNERAL DIRECTOR NAME J. G. CONNELLY				ADDRESS 300 MACE		25. DATE REC'D. BY REGISTRAR JUN 1 1984	
				26. REGISTRAR'S SIGNATURE John Davidson-Randall			

(A)

Handwritten notes and calculations on lined paper, including:

- Top left:  $1/2 + 1/3$
- Top right:  $1/2 + 1/3$
- Middle left:  $1/2 + 1/3$
- Middle right:  $1/2 + 1/3$
- Bottom left:  $1/2 + 1/3$
- Bottom right:  $1/2 + 1/3$

Other visible text includes "DATE", "TIME", and "PLACE".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Roberta			MIDDLE Roberts			LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5/2/84 19			2b. HOUR M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 27 1909		6. AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 5/2/84 19			2d. HOUR P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker				12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3204 Dorithan Road Baltimore, Maryland 21215							
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Payne											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-0240		17. INFORMANT ADDRESS Donald Roberts 3204 Dorithan Rd. Baltimore, Maryland 21215											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic Lung Disease																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 5/3/84					
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/5/1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME Nutter & Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216										25a. DATE REC'D. BY REGISTRAR MAY 4 1984							

MEDICAL CERTIFICATION



U. S. A.

U. S. A.

U. S. A.

U. S. A.

No.

No.

U. S. A.

U. S. A.

U. S. A.

U. S. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>(Roberts) WINFIELD MIDDLE (Winfield) ROBERTS</i>				7b. HOUR <i>10 54 M</i>			
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 11 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>79 YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Providence Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13e. STREET ADDRESS / ZIP CODE <i>3809 Rokeby Road 21229</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Roberts</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Evalene Eley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-07-2653</i>		17. INFORMANT ADDRESS <i>Hazel Short 6805 Brompton Road</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Arterial Embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Myocardial Infarction</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/1/84</i> , 19 <i>84</i> , to <i>5/5</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>5/5</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Walter R. Royce, MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/5/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. ROYCE III, MD</i>				22e. ADDRESS <i>2600 Liberty Heights</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>5/10/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chaple Grove Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Windsor, Va.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm C March F/H Inc, 1101 E North Avenue</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 8 1984</i>			
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

34  
A



(B) (C)

(D)

1. The first part of the document is a description of the system. It is a system of three interconnected components, each of which is a rectangular block. The components are connected by lines, and the system is shown in a perspective view. The first component is a rectangular block with a small circle on its top surface. The second component is a rectangular block with a small circle on its top surface. The third component is a rectangular block with a small circle on its top surface.

2. The second part of the document is a description of the system. It is a system of three interconnected components, each of which is a rectangular block. The components are connected by lines, and the system is shown in a perspective view. The first component is a rectangular block with a small circle on its top surface. The second component is a rectangular block with a small circle on its top surface. The third component is a rectangular block with a small circle on its top surface.

3. The third part of the document is a description of the system. It is a system of three interconnected components, each of which is a rectangular block. The components are connected by lines, and the system is shown in a perspective view. The first component is a rectangular block with a small circle on its top surface. The second component is a rectangular block with a small circle on its top surface. The third component is a rectangular block with a small circle on its top surface.

4. The fourth part of the document is a description of the system. It is a system of three interconnected components, each of which is a rectangular block. The components are connected by lines, and the system is shown in a perspective view. The first component is a rectangular block with a small circle on its top surface. The second component is a rectangular block with a small circle on its top surface. The third component is a rectangular block with a small circle on its top surface.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Bilal Dana Robinson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 19 1984</b>		2b. HOUR <b>9:20AM</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 19 1984</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>6 YRS 11 MONTHS 22 DAYS</b>	IF UNDER 1 YEAR MONTHS DAYS <b>11 MONTHS 22 DAYS</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>city</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Derrick Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stephanie Robinson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1597 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Congenital Anomalies</b>					<b>immediate</b>
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 19</b> , 19 <b>84</b> , to <b>May 19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>May 19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Lillian R. Blackmon, M.D.</b> DEGREE				22c. DATE SIGNED <b>May 19, 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lillian R. Blackmon, M.D.</b>				22e. ADDRESS <b>Dept. Pediatrics - University Md. Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>5/24/84</b>		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 29 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Lillian R. Blackmon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FILED

1934

1934

Baltimore City

Department of Public Works

1934

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works

Department of Public Works



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNETTE ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR MAY 23 1984		2b. HOUR 8:46 AM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 2-6-1913	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FACTORY WORKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13a. COUNTY BALTO 13c. CITY OR TOWN BALTO			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3907 VOLANDO RD	
14. FATHER'S NAME SHEARMAN WILSON		15. MOTHER'S MAIDEN NAME MAUDE CROCKETT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO.		17. INFORMANT LUTISIA ROBINSON PT. S/A			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MULTI system ORGAN FAILURE

1809

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) POST-OP Complications

DUE TO, OR AS A CONSEQUENCE OF

(c) CARCINOMA OF CERVIX STAGE 2A

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 5/22/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Abscess	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/1, 19 84, to 5/23, 19 84, that (I) (we) last saw the deceased alive on 5/23, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Stephanie Mason MD	DEGREE MD	22c. DATE SIGNED 5/23/84	22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Stephanie MASON MD		22f. ADDRESS Union Memorial Hosp. Balt. Md	

23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial	23b. DATE 5-29-84	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Brown-Thompson FH		25a. DATE REC'D. BY REGISTRAR MAY 25 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

APR 1 1951

15-11-51

A

Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 28th inst. in relation to the above matter.  
The same has been forwarded to the appropriate authorities for their consideration.  
I am, Sir, very respectfully,  
Yours faithfully,  
[Signature]

Very truly yours,  
[Signature]  
[Name]  
[Title]  
[Address]

15-11-51

ORIGINAL MINUTE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13298

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CARRIE L. ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR MAY 29 1984		2b. HOUR 9:22 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 16 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. STATE MD.			13b. COUNTY -	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN FAHEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-12-3162		17. INFORMANT ADDRESS 1924 DINEEN DRIVE CAROLYN MARCINIAK (DGHTR) 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/29 1984 to 5/29 1984, that (I) (we) lost saw the deceased alive on 4/29 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Francis X. Carmody		DEGREE MD		22c. DATE SIGNED 5/31	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. FRANCIS X. CARMODY		22e. ADDRESS 3201 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6/1/84	23c. NAME OF CEMETERY OR CREMATORY B ALTIMORE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 1 1984 Julia Davidson-Randall			

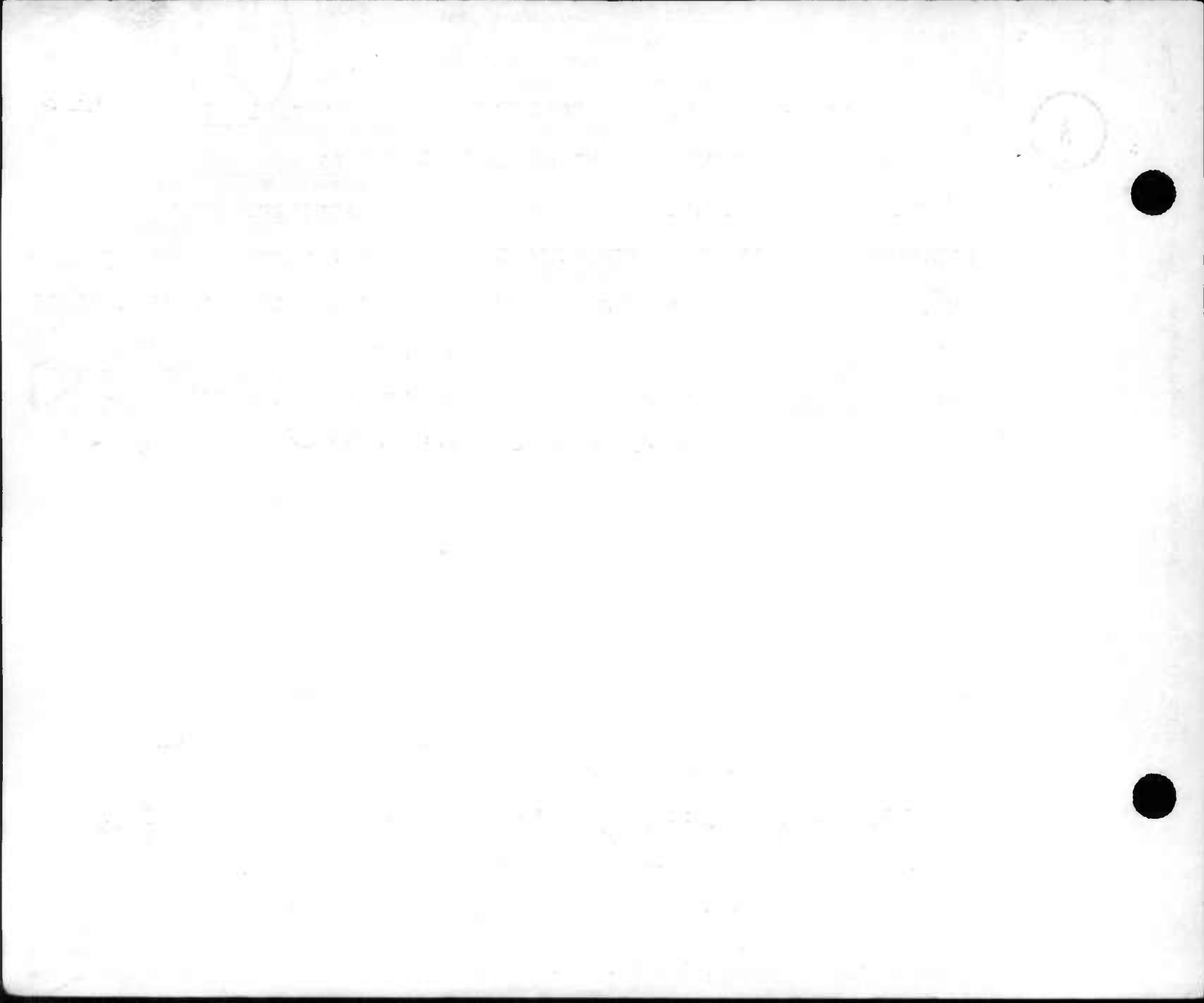
This certificate must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



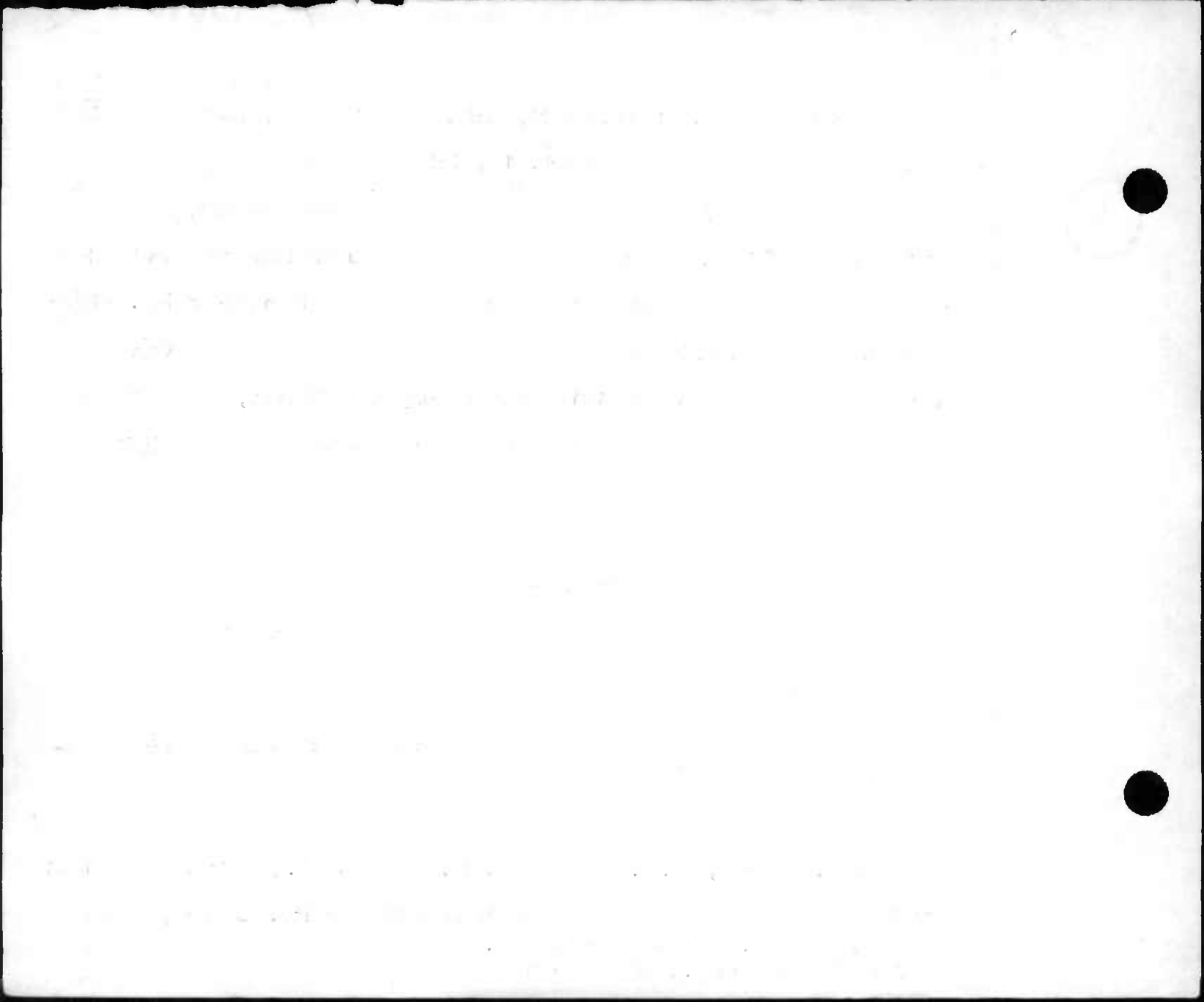
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked for item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR		
CARROLL E. ROBINSON, SR.					May 23, 1984					3 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		Sept. 16, 1893			90 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA					Baltimore City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		3809 Fenchurch Road			Supervisor of Service-Hotel							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MD				Baltimore				3809 Fenchurch Rd. 21218				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Elmer Robinson				Ida Evans								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No				215 03 1319		Hilda Burgee Robinson, Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF PANCREAS</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MONTHS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PNEUMONIA</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <del>the hospital</del> attended the deceased from <u>7-6-</u> 19 <u>73</u> to <u>5-23-</u> 19 <u>84</u> , that (I) <del>we</del> saw the deceased alive on <u>5-23-</u> 19 <u>84</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did not) view the body after death.												
22b. SIGNATURE <u>Carlton L. Sexton M.D.</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5-24-84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carlton L. Sexton, M.D.						22e. ADDRESS 901 N. Howard St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		5/26/84		Moreland Memorial		Balto. County, MD						
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
4905 York Road Balto., MD 21212						MAY 25 1984		<u>Lia Davidson-Randall</u>				



DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Essie		MIDDLE mae		LAST Robinson		2a. DATE KNOWN OF DEATH X ESTIMATED MONTH 5 DAY 6 YEAR 1984		2b. HOUR 10:04 a.m.	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH 2 DAY 14 YEAR 97		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH 5 DAY 6 YEAR 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WOMAN		12b. KIND OF BUSINESS OR INDUSTRY BAL 40-95	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5511 STONINGTON RD BAL 40-95			
14. FATHER'S NAME FIRST MIDDLE LAST George Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARRIE PRINCE				17. INFORMANT ADDRESS NORM. STEWART 3661 COTL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS NORM. STEWART 3661 COTL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? BODY ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 5/7/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/10/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME Marshall H. Wagoner						ADDRESS 1383 Gilmour St		25a. DATE REC'D. BY REGISTRAR MAY 9 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



*Handwritten signature or name, possibly "L. L. L." or similar.*

1914



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Pietro Rodgers AKA. Peter Rodgers		5-24-84		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YEAR	
Male	White	7-26-98	85	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Penn.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto.		Caton Manor N. Home		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21012 P.O. Box 9745 Arnold Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Joe Rodgers		Agnes Rodgers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
		207-12-6131		P.O. Box 9745 Josephine Rodgers Arnold, Md, 21012	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
4379 IMMEDIATE CAUSE (a) Dehydration					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Cerebrovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Osteoarthritis, Parkinsonism					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9:21, 1978, to 5:24, 1984, that (I) (we) lost saw the deceased alive on 4:30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
S. D. Autia		M.D.		5.25.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
S.D. AUTIA		5400 OLD COURT ROAD, RANDALLS TOWN, MD 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation	6-4-84	Westview	Catonsville MD.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Chas. A. Rice FSPA		1300 Eutaw Place		JUN 7 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



• 574 •

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AUGUST 1960

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

482 D. B. Clark

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

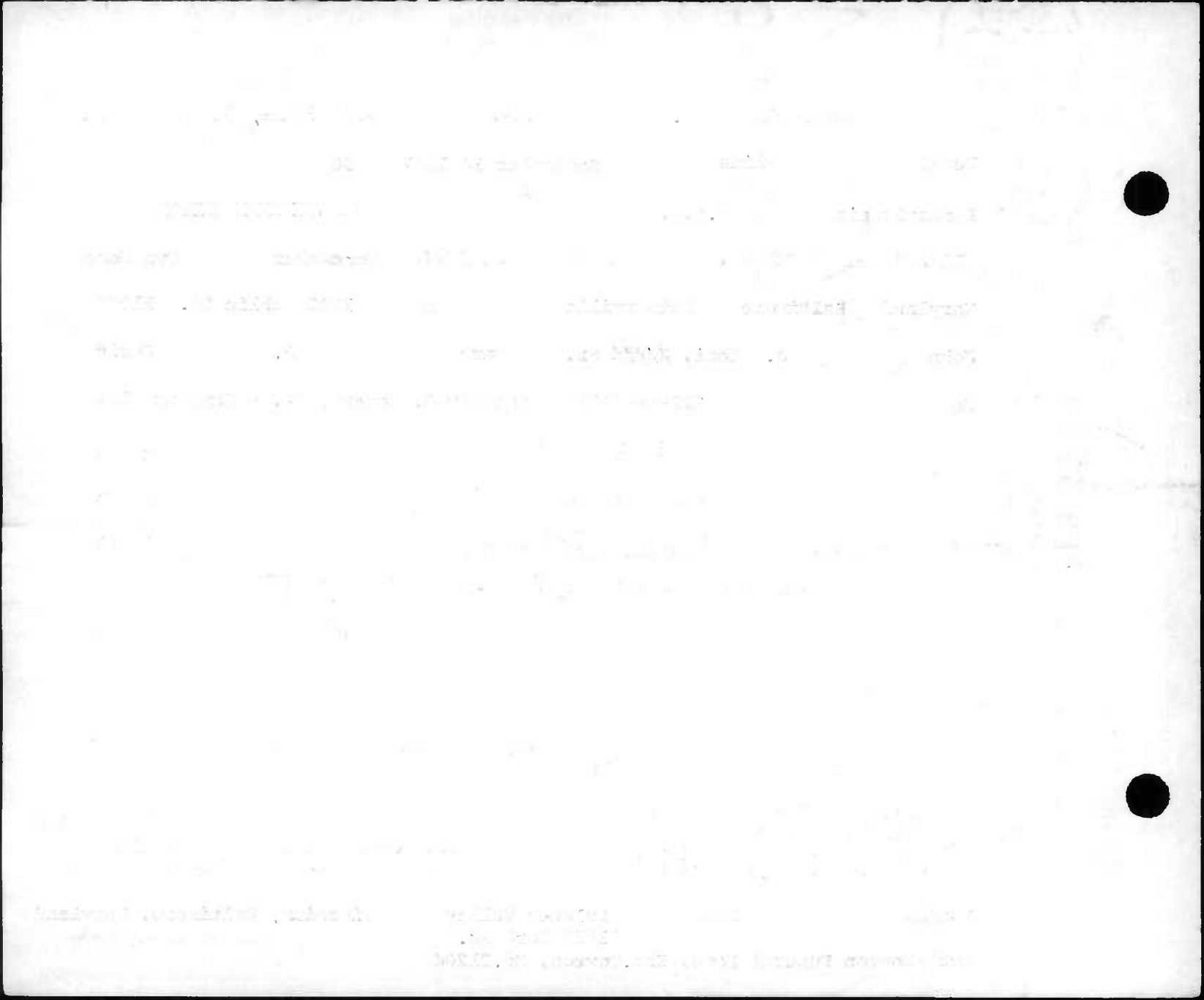
REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BARBARA A. ROMANO</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 30TH, 1984</b>  |  | 2b. HOUR P<br><b>9:00 AM</b>  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 14, 1947</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>36</b> YRS  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Lutherville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>1202 Dublin Ct. 21093</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Toni, Sr.</b>  |  |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Juris</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  |
| 17. SOCIAL SECURITY NO.<br><b>212-46-4371</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Anthony J. Romano, Jr. - Same as #13e</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4589 IMMEDIATE CAUSE (a) Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypoxia - ? etiology</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 min</b><br><b>12 hrs</b><br><b>days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Carcinoma of breast; Autologous Bone Marrow Transplant</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>5/30</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>5/5</b> 19 <b>84</b> to <b>5/30</b> 19 <b>84</b> , that (1) (we) lost <b>5/30</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard Bennett</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>5/30/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Bennett</b>   |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL<br/>601 N. Wolfe St Baltimore 21205</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6-2-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore, Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |   |  |
| 25. DATE REC'D. BY REGISTRAR<br><b>5/31/84</b>  |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, pages 1 and 2 should be filed with the funeral director. Page 4 may be retained by the funeral director. Page 5 should be filed with the State Department of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury or trauma, the death certificate must be filed with the State Department of Health and Mental Hygiene.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                      |  |  |  |   |  |   |  |   |  |   |  |
|--|--|----------------------|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Otis</b> <b>Rorie</b>   |  |                      |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 5 5 19 84 |  | 2b. HOUR <input checked="" type="checkbox"/> M 5:56A                                |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>BLACK</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5 25 34</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>49</b>                 |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 6 19 84</b>   |  | 7d. HOUR <b>5:56A</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1610 Ashburton Ave.</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>                                |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1610 Ashburton St. 21216</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eliziah Rorie</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie</b>     |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO.<br><b>245-46-0431</b>   |  | 17. INFORMANT ADDRESS<br><b>Inez Rorie 1610 Ashburton Street</b>  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4512</b> IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Leg vein thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                      |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accidental <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |  |                      |  | TITLE (SPECIFY)<br>M.D. <b>Deputy Chief</b>  |  |   |  | DATE SIGNED<br><b>5/6/84</b>  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT) <b>BURIAL</b>   |  |                      |  | 23b. DATE<br><b>5/12/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Galilee Bapt.Ch.Cem.</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marvin, N.C.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1984</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13304

|  |  |  |  |  |  |  |   |  |  |   |                                     |  |  |
|--|--|--|--|--|--|--|---|--|--|---|-------------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |  |  |  |   |  |  |   |                                     |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Julius Roseman</i>  |  |  |  |  |  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5/13/84</i> |                                     | 2b. HOUR<br><i>756A</i>                            |  |
| 3. SEX<br><i>MALE</i>  |  |  | 4. RACE<br><i>CAU.</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>01 XSE 14 1922</i>            |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>84</i>  |  |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.  |   |                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI HOSPITAL</i> |  |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>CLERK</i>   |   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>RETAIL</i> |  |
| 13a. STATE<br><i>MARYLAND</i>  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>3612 FORDS LA.</i>   |   |                                     | APT. D<br><i>#21215</i>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>AARON ROSEMAN</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ESTHER UNKNOWN</i> |  |   |  |  |   |                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>213-20-8530</i>   |  |  | 17. INFORMANT<br>ADDRESS<br><i>MISS MARY ROSEMAN, APT. D<br/>3612 FORDS LA. BALTO., MD 21215</i>   |   |  |  |   |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>4960</i> IMMEDIATE CAUSE (a) <i>respiratory arrest</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <i>COPD &amp; mucus plugs</i><br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |  |  |  |  |  |   |  |  |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |   |  |  |   |                                     |  |  |
| 19a. DATE OF OPERATION<br><i>4/23/84</i>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>pericardiectomy</i>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |                                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/13/84</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |   |  |  |   |                                     |  |  |
| 22b. SIGNATURE<br><i>WOWK</i>  |  |  |  |  |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>5/13/84</i>                    |                                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WOWK</i>   |  |  |  |  |  | 22e. ADDRESS<br><i>Sinai Hosp</i>  |   |  |  |   |                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>MAY 15, 1984</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MIKRO KODESH BETH ISRAEL</i>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MARYLAND</i>  |  |   |                                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 16 1984</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |                                     |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  |  |   |  |  |   |                                     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE STATE OF TEXAS  
COUNTY OF DALLAS  
FILE NO. 12345

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                             |  |  |   |  |
|--|--|--|--|---|-----------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Walter L. Rosenbaum</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>05 15 84</i> |   | 2b. HOUR<br><i>12:20 PM</i> |  |  |   |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>04 11 1898</i>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i> YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MICHIGAN</i>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI HOSPITAL</i> |  |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR FORM OF WORKING LIFE)<br><i>XXXXXX</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>PANT CO.</i>            |  |

|  |  |  |  |  |                                       |  |   |  |  |  |
|--|--|--|--|--|---------------------------------------|--|---|--|--|--|
| 13a. STATE<br><i>MD</i>  |  |  | 13b. COUNTY<br><i>BALTIMORE</i>  |  | 13c. CITY OR TOWN<br><i>BALTIMORE</i> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>22 PALMER GREEN, 21210</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>LOUIS ROSENBAUM</i>                   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>AMANDA FROZEN</i>      |  |                                       |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>YES</i> |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WWI-ARMY</i> |  |                                       | 17. INFORMANT<br>ADDRESS<br><i>MRS. ADELE C. ROSENBAUM 22 PALMER GREEN 21210</i> |   |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i><br>4039<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>chronic renal failure</i><br>(c) <i>HTN</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>5/7 19 84</i>    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>Belvedere &amp; Greenspring Ave. BALTIMORE MARYLAND</i>                                      |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/7</i> , 19 <i>84</i> , to <i>5/15</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>5/15</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>J. Ford MD</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>5/15/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>J. Ford</i>  |  |  |  | 22e. ADDRESS<br><i>Belvedere &amp; Greenspring Ave.</i>  |  |  |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>EMERGENCY CREMATION</i>  |  | 23b. DATE<br><i>5/16/84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>LOUDON PARK CREM</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MARYLAND</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i><br><i>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</i> |  |                             |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 23 1984</i>                     |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |                             |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

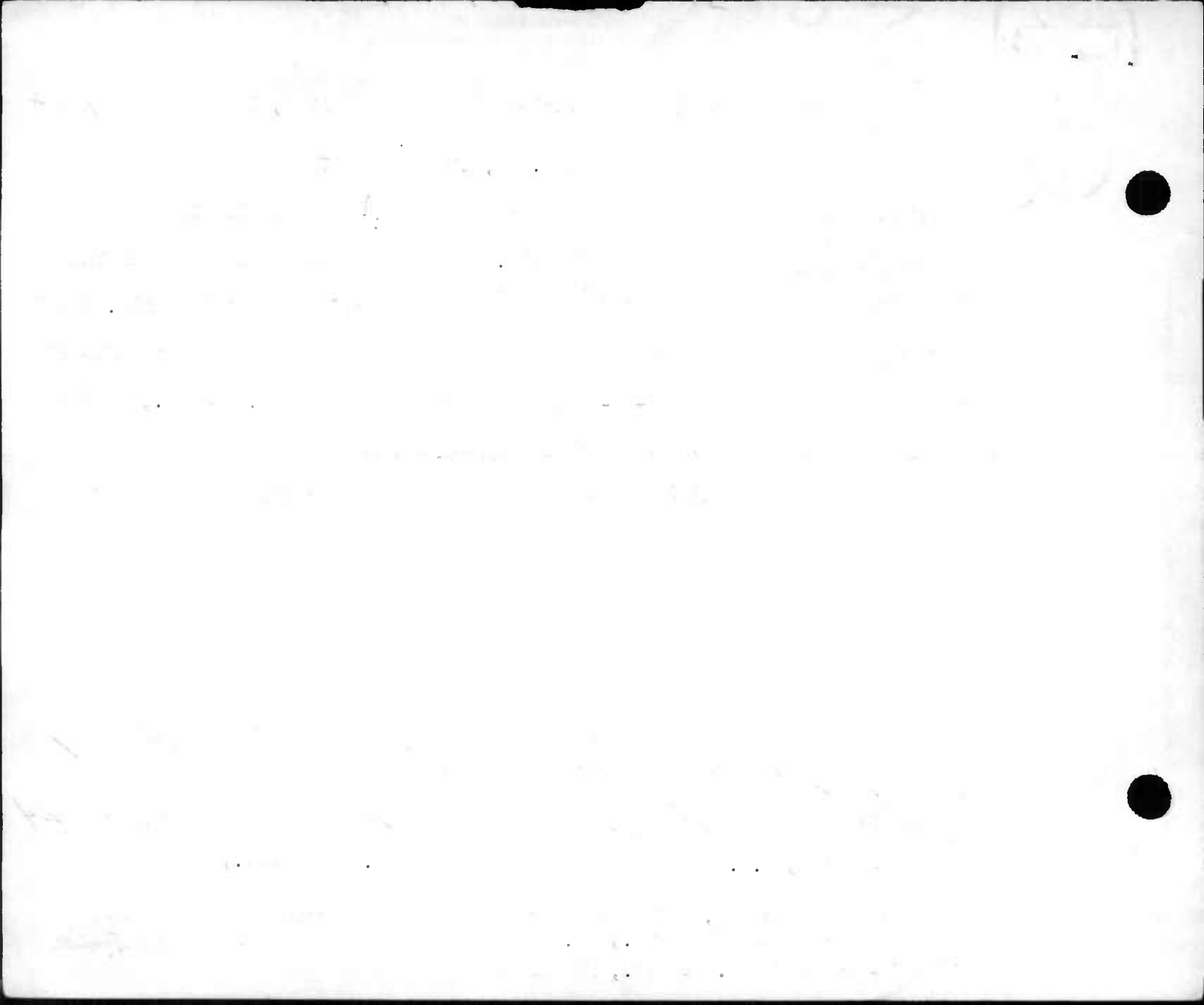
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |                                |  |  | REG. NO. |
|--|--|--|--|---|---|--|--------------------------------|--|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ISAAC (ISADORE) ROSENBERG   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 4, 1984 |  | 2b. HOUR<br>7:00 <sup>AM</sup> |  |  |          |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOV. 13, 1905  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>78  |                                | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |                                |  |  |          |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3034 CHESTERFIELD AVE. |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HANDYMAN  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHIP YARD   |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13d. STREET ADDRESS / ZIP CODE<br>3034 CHESTERFIELD AVE. 21213   |                                |  |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARRY ROSENBERG   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNA YANKOLOVITZ  |   |  |                                |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>218-10-6930  |  | 17. INFORMANT ADDRESS<br>MARIE GEMMILL 3034 CHESTERFIELD AVE. BALTO., MD 21213  |   |  |                                |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |   |  |                                |  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |   |  |                                |  |  |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                                |  |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |                                |  |  |          |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March 4</u> , 19 <u>82</u> , to <u>May 4<sup>th</sup></u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Jan 12<sup>th</sup></u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (do not) view the body after death. |  |  |  |   |   |  |                                |  |  |          |
| 22b. SIGNATURE <u>George Taler</u>   |  |  |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                | 22c. DATE SIGNED <u>May 4<sup>th</sup> 1984</u>  |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE TALER, M.D.  |  |  |  | 22e. ADDRESS<br>600 LIGHT ST. BALTO., MD  |   |  |                                |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MAY 6, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |                                |  |  |          |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAY 8 1984 <u>Chae Davidson-Randell</u>   |   |  |                                |  |  |          |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                            |  |  |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Margaret Rosenblatt</i>                                |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>5 17 84</i> |   | 2b. HOUR<br><i>9.16 AM</i> |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>1 1 22</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>62</i>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Germ.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Cty</i> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Union Memorial Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Seamstress</i>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Schwartz Co</i>                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD</i> |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Thomas Woodly</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Florence E. Marton</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>   |                            |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>229247584</i>   |  | 17. INFORMANT ADDRESS<br><i>Samuel Rosenblatt 304 W. 30th St</i>  |  |   |                            |  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 5/10</i> , 19 <i>84</i> , to <i>5/17</i> , 19 <i>84</i> , that (I) (we) lost the deceased alive on <i>5/10</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Evangelos Lignos</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>5-17-84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Evangelos Lignos</i>  |  |   |  | 22e. ADDRESS<br><i>201 E. University Pkwy, Baltimore, 21218</i>  |  |   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                         |  | 23b. DATE<br><i>5/21/84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Vernon</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Harrison Ford Md.</i> |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>Paul Elchenowith 3615-19 Chestnut Ave.</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>MAY 18 1984 Julia Davidson-Rendell</i> |  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified thereof.

20% COTTON

DAVID L. M. W.



Bureau

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

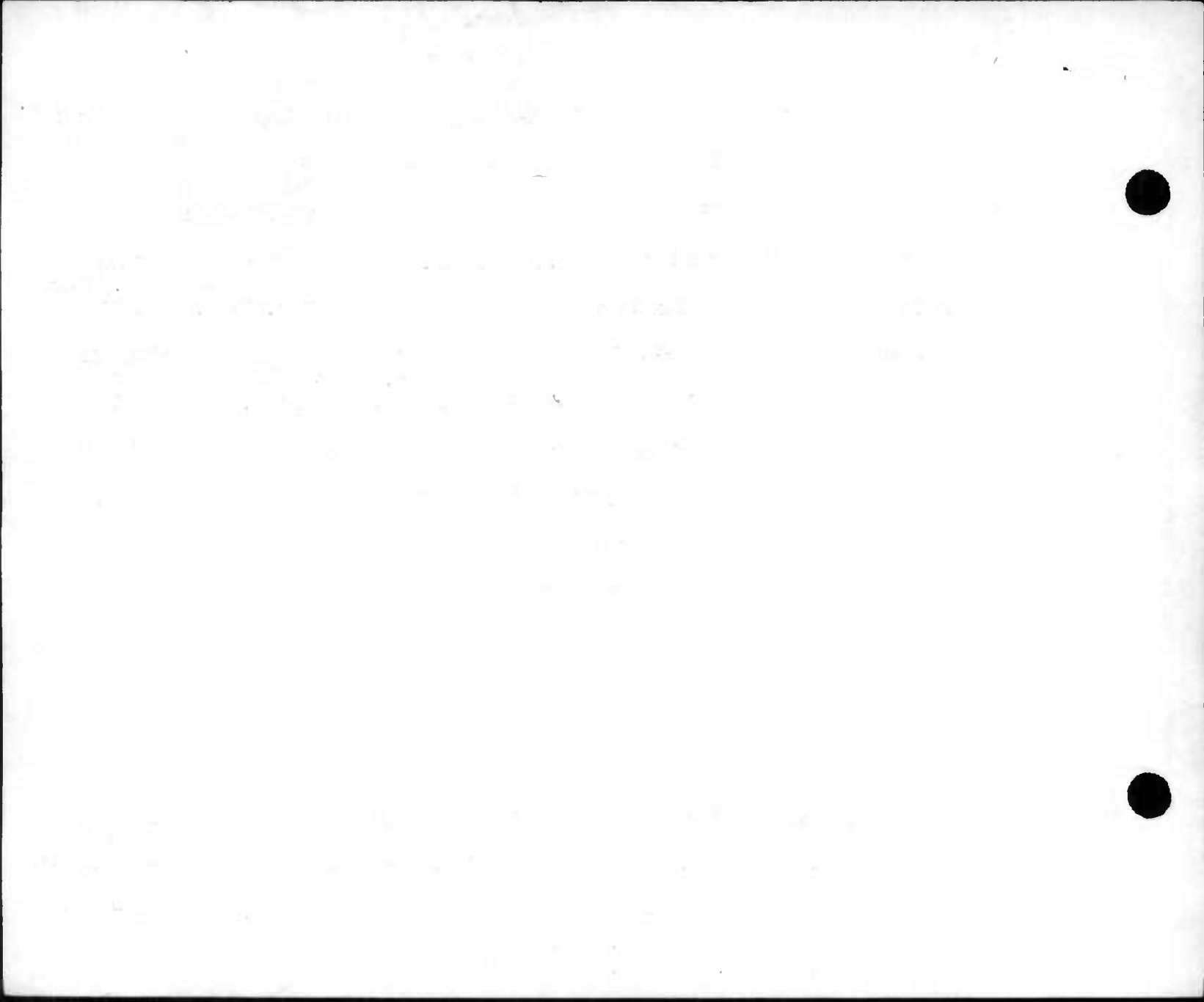
REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>NAOMI ROSENOUR   |  | MONTH DAY YEAR<br>MAY 25, 1984   |   | P. M.<br>8:45  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| FEMALE  | WHITE  | MONTH DAY YEAR<br>JULY 2, 1895   |   | 88 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| MARYLAND  | USA  |  |   | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE   | 116 UNIVERSITY PKWY., APT. 1109  | HOUSEWIFE  |   | AT HOME  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE   |  |
| MARYLAND  |  | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | APT. 1109<br>116 UNIV. PKWY. #21210  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |  |
| SELIG SEIDENMAN   |  | MARY SEIDENBERG  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |
| NO  |  | 076-01-93630   |   | MR. MASON MYERS<br>7615 CARLA RD. BALTO., MD 21208                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |  |   |  |  |
| 5303 IMMEDIATE CAUSE (a) <u>respiratory failure</u>   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |
| (b) <u>aspiration pneumonia</u>   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
| (c) <u>esophageal stricture</u>   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>breast cancer</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHERE AT WORK <input type="checkbox"/> NOT WHERE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Richard A. Berg</u>   |   | 22c. DATE SIGNED<br>5/26/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |
| RICHARD A. BERG, M.D.   |  | 711 W. 40th St., Suite 400 BALTO., MD  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL  |  | MAY 27, 1984   |   | HEBREW FRIENDSHIP  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  | MAY 31 1984  |   | <u>Sol Levinson</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |   |  |
|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DECEASED NAME (TYPE OR PRINT) <b>JULIAN ROSENSTOCK</b>   |   | 2b. DATE OF DEATH MONTH DAY YEAR <b>5 12 84</b>  |  | 2c. HOUR <b>12<sup>36</sup> P<sup>M</sup></b>   |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> 75 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>                  |   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTIMORE</b>   | 13c. CITY OR TOWN <b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS <b>APT. E 3000 FALLSTAFF MANOR CT. 21209</b> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM ROSENSTOCK</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GERTRUDE HAMBURGER</b>   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT <b>FREIDA ROSENSTOCK APT. E 3000 FALLSTAFF MANOR CT. BALTO., MD 21209</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4100</b>  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>4100</b>  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-8</b> , 19 <b>84</b> , to <b>5-12</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5-12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |
| 22b. SIGNATURE <b>Elto Rad Novoa</b>  |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>5/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elto Rad Novoa</b>   |  | 22e. ADDRESS <b>SINAI HOSP. - BALTO., MD</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>MAY 14, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>   |  | 23d. LOCATION CITY OR TOWN <b>REISTERSTOWN BALTO. MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |   | 25. DATE REC'D. BY REGISTRAR <b>MAY 15 1984</b> REGISTRAR'S SIGNATURE <b>Jane Davidson-Rodell</b>  |  |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |   |  |  |   |  |

13302

13302

13302



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |   |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
|--|--|--|---|---|---|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH ROSINOLA</b>                                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 18 1984</b> |   | 2b. HOUR<br><b>8 P M</b>  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 4 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>426 N. EAST AVE. 21224</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINE OPERATOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MARTIN CO.</b> |   |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b> |  |  |   | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET ADDRESS / ZIP CODE<br><b>426 N. EAST AVE. 21224</b> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ADOLPH ROSINOLA</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PALMA -</b>   |   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>171-03-4310</b> |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>PAMELA LOREK (DGHTR) 3670 KENYON AVE. 21213</b> |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe ventricular irritability</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe ischemic cardiomyopathy</u>  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>1-2 yr</u><br><u>3-5 yr</u>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>83</u> , to <u>5-17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Shelia G. Walker</u>  |  |  |  |  |  |  |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>5-21-84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SHELIA WALKER</b>  |  |  |  |  |  |  |  | 22e. ADDRESS<br><b>3411 BANK ST.</b>   |  |  |  |

|  |  |                             |  |   |  |  |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/22/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b> |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Baltimore Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SCHIMUNEK FUNERAL HOME, INC.<br/>3331 Brehms Lane, Balto. Md. 21213</b> |  |                             |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jake Davidson</u> |  |

BP



LIBRARY

UNIVERSITY OF CALIFORNIA  
LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Winfield H. Ross, Sr.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 12, 1984 |   |  | 2b. HOUR<br>7:45 AM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 1 93  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1914 Lauretta Avenue |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan J. Ross  |   | 13e. STREET ADDRESS / ZIP CODE<br>1914 Lauretta Ave. 21223  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-10-1890  |   | 17. INFORMANT<br>ADDRESS<br>Mary M. Ross 1914 Lauretta Avenue   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF BIRTH, FATHER'S MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21g. DATE OF INJURY<br>5/12/84  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/12/84</u> to <u>5/12/84</u> , that (I) (we) last saw the deceased alive on <u>5/12/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>D. W. Stewart, M.D.</u>  |  | 22c. ADDRESS<br><u>2300 GARRISON BLVD.</u>  |   | 22d. DATE SIGNED<br><u>5/14/84</u>  |  | 22e. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>5/17/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oldfield Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Oldfield Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Davidson-Randall</u>  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Phillip J. Rosso</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 10 1984</b>                                       |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 2 1905</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>79</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Medical Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Supervisor</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hutzlers</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN  | 13e. STREET ADDRESS / ZIP CODE<br><b>7000 Lancaster Road 21207</b>                              |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Rosso</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Rosso</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214-01-1092</b>   |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Maryann Rankin 21043<br/>3347 North Chatham Road Ellicott City Maryland</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3109</b> IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DECUBITUS ULCERATION WITH OSTEOMYELITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ORGANIC BRAIN SYNDROME</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11c   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>84</b> , to <b>5/10</b> , 19 <b>84</b> , that (b) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.        |   |  |   |  |  |
| 22b. SIGNATURE<br><b>M. Daly</b>  |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. DALY</b>   |   | 22e. ADDRESS<br><b>DEATON MEDICAL CENTER</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>5-12-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1984</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours deadline with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and/or

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR <b>RICHARD EARL ROUPE</b>  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Richard EARL Roupe</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR 5 3 84   |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b>  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 1 1 31  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>steelworker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>  |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>A.A.</b>   |  |
| 13c. CITY OR TOWN <b>Pasadena</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE <b>409 Greenland Beach Rd. 21226</b>   |  |   |  |
| 14. FATHER'S NAME (TYPE OR PRINT) <b>Charles</b> MIDDLE LAST <b>Roupe</b>   |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Olga</b> FIRST MIDDLE LAST <b>?</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATE)   |  | 16b. SOCIAL SECURITY NO. <b>219-28-6099</b>   |  |
| 17. INFORMANT ADDRESS <b>Mrs. Richard Roupe (same as 13E)</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>Hepatorenal syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic colon CA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>6 months</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |  |
| 19a. DATE OF OPERATION <b>5/2/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>closed shunt</b>  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |
| 21c. INJURY OCCURRED (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21d. PLACE OF INJURY (STREET CITY OR TOWN COUNTY STATE)   |  |
| 21e. I certify that I (we) hospital attended the deceased from <b>4/23/84</b> 19 to <b>5/3/84</b> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so say the deceased on the above.)   |  | 21f. SIGNATURE <b>Robert P. W. 715</b> DEGREE <b>BC H.</b>  |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert P. W. 715</b>   |  | 22b. ADDRESS <b>BC H.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>  |  | 23b. DATE <b>5/5/84</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>  |  | 23d. LOCATION <b>Baltimore Balto. Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hwy. Baltimore Md. 21225</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 7 1984</b>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Henderson</b>   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth A Rousey</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>11</b> YEAR <b>94</b>                    |  | 2b. HOUR <b>4:34</b> M                           |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>03</b> YEAR <b>22</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>BALTO, MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO city</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. Maryland Hosp. b2</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>BALTO</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>CLARENCE</b> MIDDLE <b>SMITH</b> LAST <b>SMITH</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAMMIE</b> MIDDLE <b>CUNY</b> LAST <b>CUNY</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br><b>219-404784</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Luther Rousey 111 W. Centre St.</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>① Frontal Intracerebral Bleeding</b><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>METASTATIC CARCINOMA, UNK. PRIMARY</b><br>(c) <b>②</b><br>DUE TO, OR AS A CONSEQUENCE OF |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11/84</b> 19 <b>84</b> to <b>5/11</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/11</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Hector Silva</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>5/11/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hector Silva</b>  |   | 22e. ADDRESS<br><b>UMCC, 22 S Green St BALTO.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>Burial</b>   |   | 23b. DATE<br><b>5/16/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn</b>                            |  |
| 23d. FUNERAL DIRECTOR<br>NAME<br><b>The Bailey Funeral Home</b>   |   | 23e. ADDRESS<br><b>1348 N. Calhoun</b>  |   | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |  |
| 24. DATE RECD. BY REGISTRAR<br><b>MAY 14 1984</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |  |

BP

20/10/20

6/10/09

2/11/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a

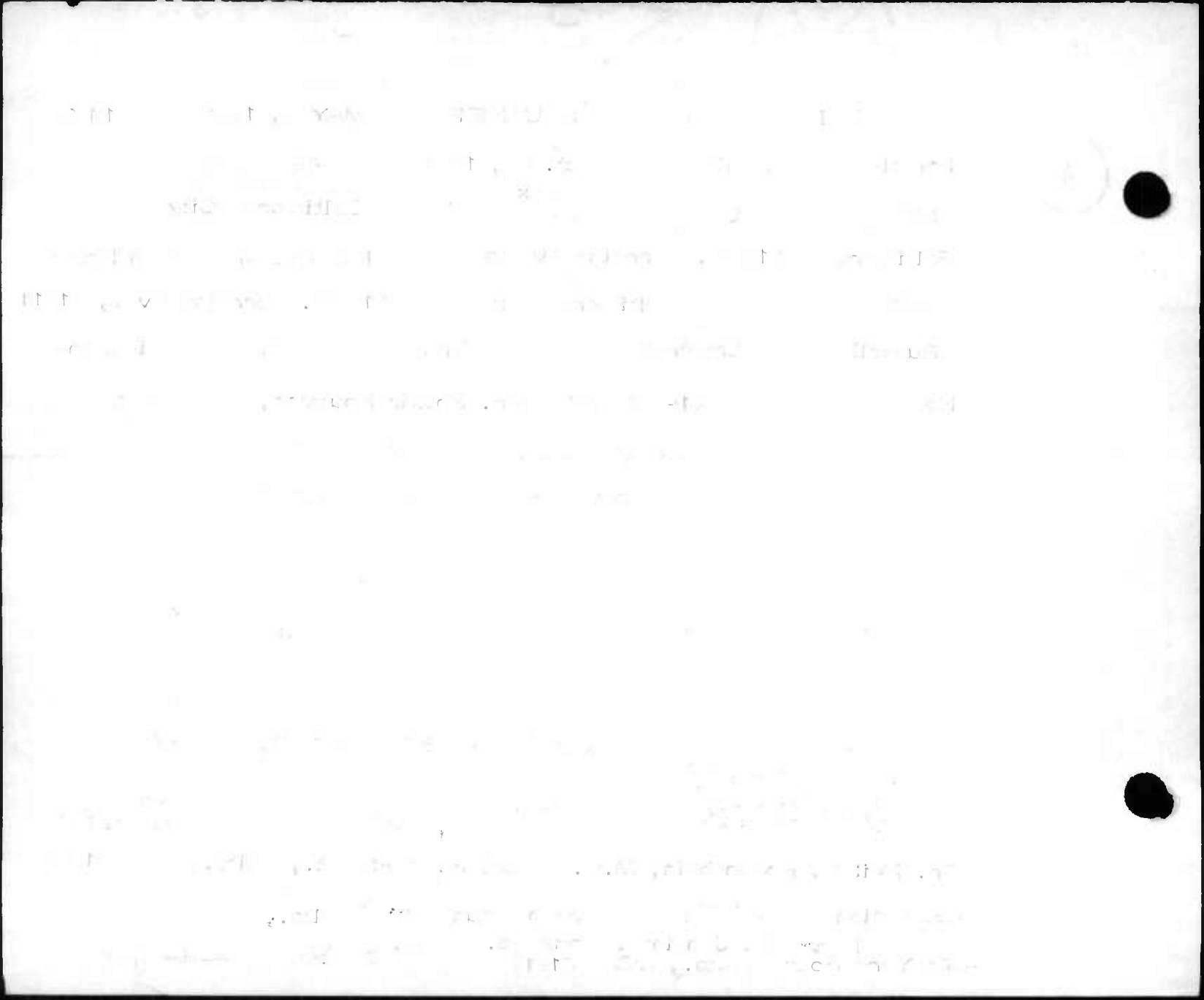
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LOIS ANN ROUTHIER   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 6, 1984                            |   | 2b. HOUR<br>11:30 AM   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 28, 1934   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>319 W. Lorraine Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Russell Crabtree  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma A. Simmons  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>219 30 4532   |   | 17. INFORMANT<br>ADDRESS<br>Mr. Phillip Routhier, Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>1809<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Cervical Cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Oct 6 to 27, 1983</u> to <u>6 May 84</u> , that (2) (we) last saw the deceased alive on <u>25 Mar 84</u> , and that in (3) (my) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Neil B. Rosenshein</u>   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>7 May 84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Neil B. Rosenshein, M.D.   |   | 22e. ADDRESS<br>600 N. Wolfe St., Balto., MD 21205  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>5/8/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>   |  |

BP



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |  |  |   |   |  |
|---|--|---|--|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILTON RUBIN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>22</b> YEAR <b>84</b>                   |   |   | 2b. HOUR<br><b>1:30A</b>   |  |  |   |   |  |
| 1. SEX<br><b>MALE M</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>8</b> YEAR <b>24</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                |   | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTUARANT</b>  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XXX</b>   |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>812 WOODGLEN PL. #21208</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>MYER</b> MIDDLE <b>RUBIN</b> LAST <b>POSTER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE <b>POSTER</b> LAST <b>POSTER</b>   |   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b><br><b>WWII-ARMY</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>216-14-4603</b>  |   | 17. INFORMANT <b>MRS. ESTELLE RUBIN</b><br><b>812 WOODGLEN PLACE BALTO., MD 21208</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2000 IMMEDIATE CAUSE (a) BLEEDING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIFFUSE HISTIOCYTIC LYMPHOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE</b>  |  |   |  |   |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>RENAL FAILURE</b>   |  |   |  |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>5-3-84</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RUPTURED SPLEEN</b>         |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>5</b> DAY <b>3</b> YEAR <b>19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                        |  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |   | 21f. LOCATION<br>STREET <b>CIR.</b> CITY OR TOWN <b>ROSEDALE</b> COUNTY <b>BALTO.</b> STATE <b>MD</b> |  |  |  |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>4-27-</b> 19 <b>84</b> , to <b>5-22-</b> 19 <b>84</b> , that (1) (we) last<br>saw the deceased alive on <b>5-21-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Francis T. Khoo</b>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>5-22-84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANCIS T. KHOO</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>UMCC</b>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |   | 23b. DATE<br><b>MAY 23, 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BOBROISKER BENEFICIAL CIP.</b>                               |  |  | 23d. LOCATION<br>CITY OR TOWN <b>ROSEDALE</b> COUNTY <b>BALTO.</b> STATE <b>MD</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 25 1984</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO: 18-55-2

RUBIN

WILTON

11 8 24

W

M

BREEDING

DIFFUSE HISTIOCYTIC LYMPHOMA

RENAL FAILURE

2-3-24 RAPTURED SPERM

X

2-55-24

4/4

4-51-

24

2-51-

From the ...

FRANCIS T KHU

NMCC

X

2-55-24



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

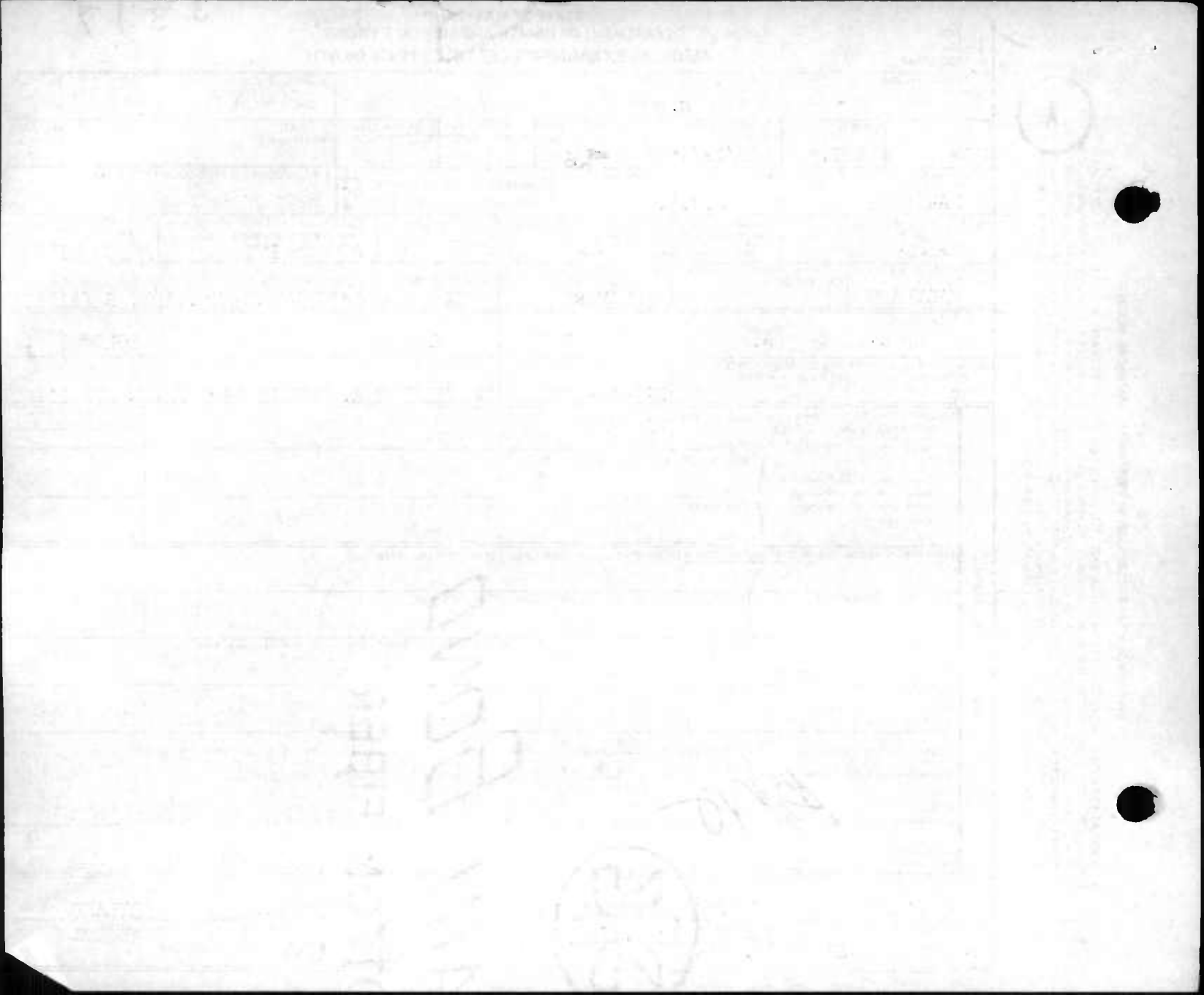
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                  |   |  |   |  |
|---|------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JORDAN GLENN RUDDIE  |                  |   | 2a. DATE KNOWN OF DEATH<br>EST. <input checked="" type="checkbox"/> MONTH DAY YEAR<br>MATED <input type="checkbox"/> 5/9/84 19 |   | 2b. HOUR<br>M<br>P   |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/13/1957  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>26 YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5/9/84 19          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>415 Lyman Avenue, Apt. #5 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ACCOUNTANT   |  |
| 13a. STATE<br>MARYLAND  |                  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GILBERT A. RUDDIE   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SHARON LOKOM   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |                  | 16b. SOCIAL SECURITY NO.<br>213-48-6201   |  | 17. INFORMANT ADDRESS<br>MR GILBERT A. RUDDIE 2603 SMITH AVE 21209  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9554 Gunshot wound to head<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                  |   |  |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 5/9/84 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>self inflicted wound   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>415 Lyman Avenue, Apt. #5, Balto., City, Md.   |  |
| 22a. I certify that I took charge of the remains described hereon. HEAD ONLY Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |
| ACTUAL SIGNATURE<br>[Signature]   |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  | DATE SIGNED<br>5/10/84  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |                  | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>5/11/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH CEM  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.  |                  | ADDRESS<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1984  |  |
|   |                  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |        |  |   |   |  |                       |   |   |            |
|---|---|---|--------|--|---|---|--|-----------------------|---|---|------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE | LAST   | 2a. DATE OF DEATH   |   | MONTH  | DAY                   | YEAR  | 2b. HOUR  |            |
| ROBERT  |   |   |        | RUFFIN   | May 9, 1984   |   |  |                       |   | 6:00 A.M.   |            |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |        |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | IF UNDER 1 YEAR  |                       | IF UNDER 24 HRS                                 |   |            |
| Male  | Black   | 8-16-19   |        |  | 64 YRS.   |   | MONTHS   |                       | DAYS  |   | HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |                       |   |   |            |
| Kinston, N.C.   | U.S.A.  |   |        |  | BALTIMORE CITY  |   | MD.  |                       |   |   |            |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |        | 12a. USUAL OCCUPATION<br>(TYPE AND NATURE OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                       |   |   |            |
| Baltimore   | THE UNION MEMORIAL HOSPITAL   |   |        | Retired<br>Ware House Man  |   |   |  |                       |   |   |            |
| 13a. STATE  |   |   |        | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE                                 |                       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |            |
| Maryland  |   |   |        |  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1741 N. Castel Street  |                       | Baltimore, MD 21218                             |   |            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 16. ADDRESS   |  |                       |   |   |            |
| DAN Ruffin  |   |   |        | Estelle Suggs  |   |   |  |                       |   |   |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   |        | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  | ADDRESS               |   |   |            |
| yes WWII  |   |   |        | 245-05-8881  |   | Mary Ruffin   |  | 1741 N. Castel Street |   |   |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br><u>4439</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Peripheral vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes, tias CRF, Lung Ca.</u> |   |   |        |  |   |   |  |                       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>6 Hours</u> |            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |        |  |   |   |  |                       |   |   |            |
| <u>Diabetes, tias CRF, Lung Ca.</u>   |   |   |        |  |   |   |  |                       |   |   |            |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                       |   |   |            |
| None  |   | None  |        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                       |   |   |            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |                       |   |   |            |
|   |   |   |        | None.  |   |   |  |                       |   |   |            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |                       |   |   |            |
|   |   |   |        |  |   |   |  |                       |   |   |            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/8</u> , 19 <u>84</u> , to <u>5/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |        |  |   |   |  |                       |   |   |            |
| 22b. SIGNATURE<br><u>Ronald W. Wish M.D.</u>  |   |   |        | DEGREE   |   |   |  | 22c. DATE SIGNED      |   |   |            |
|   |   |   |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 5/9/84                |   |   |            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RONALD WISH, M.D.  |   |   |        | 22e. ADDRESS<br>201 E. UNIVERSITY PARKWAY<br>BALTIMORE, MARYLAND 21218   |   |   |  |                       |   |   |            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)  |   | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                       |   |   |            |
| Burial  |   | 5-14-84   |        | Baltimore Cemetery   |   | Baltimore Maryland  |  |                       |   |   |            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   |   |        | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |                       |   |   |            |
| William J. Spohn 1639 N. Broadway   |   |   |        | MAY 11 1984  |   | Julia Davidson-Randall  |  |                       |   |   |            |

BP

11

Item 13a per form 5/16/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

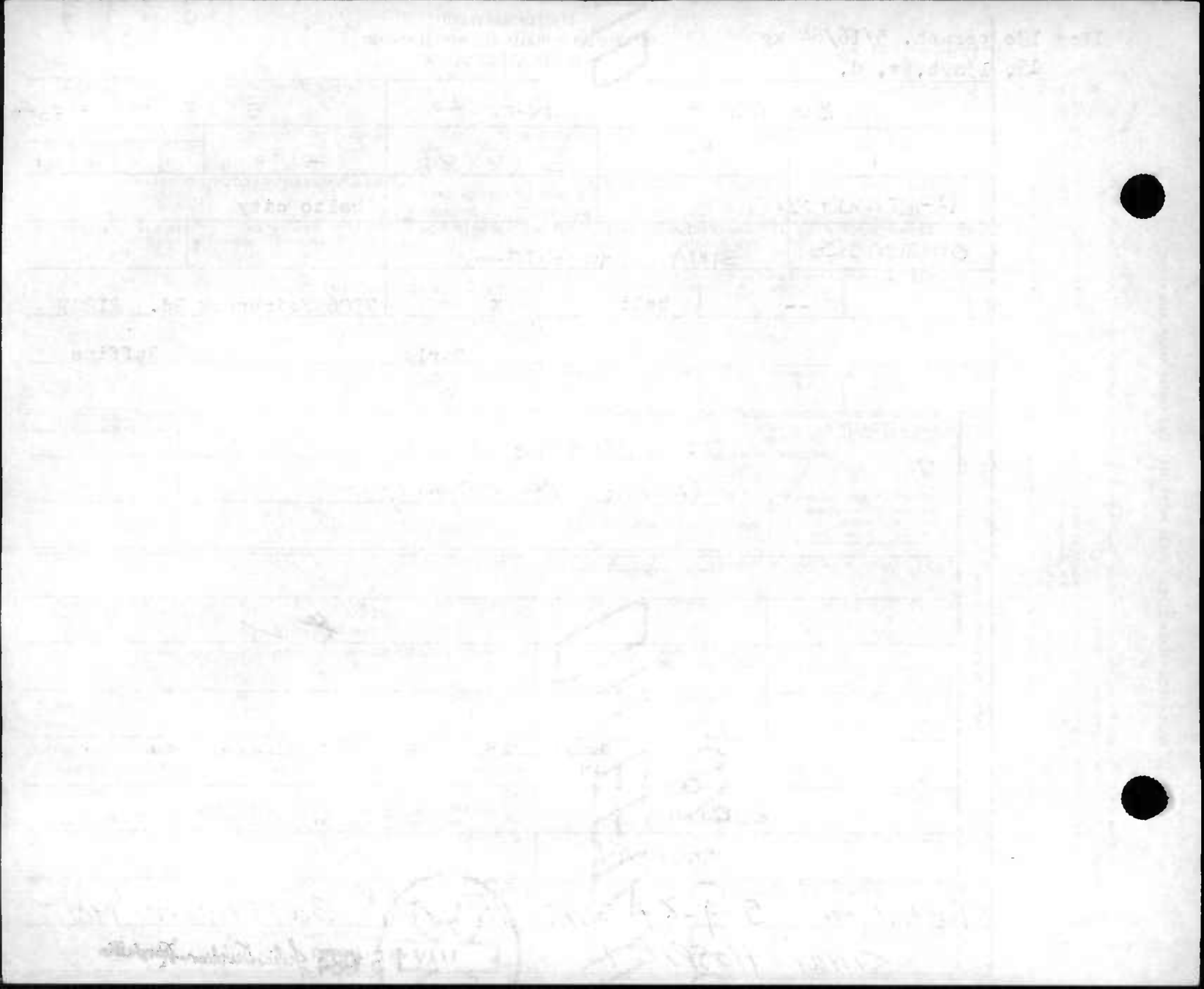
|  |                     |  |   |  |                           |
|--|---------------------|--|---|--|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BG DARLA RUFFINS</b>          |                     |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>8</b> YEAR <b>84</b> |  | 2b. HOUR<br><b>8:53pm</b> |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b> | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>8</b> YEAR <b>84</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>4 hrs.</b> YRS. MONTHS <b>4</b> DAYS <b>01</b> |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>     |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>MD</b>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>balto city</b> MD                         |                           |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                        |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                           |
| 13a. STATE<br><b>Md</b>  |                     | 13b. COUNTY<br><b>--</b>   |   | 13c. CITY OR TOWN<br><b>balto</b>  |                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                               |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 17. INFORMANT ADDRESS<br><b>Darla Ruffins</b>  |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |   | 17. INFORMANT ADDRESS  |                           |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b><br><b>7650</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>EXTREME PREMATURITY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4:50pm 5/8 1984</b> to <b>5:18 8:53pm 1984</b> , that (I) (we) last saw the deceased alive on <b>5/8 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>N. Raganan</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>5/8/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAGAVAN</b>  |  | 22e. ADDRESS   |  | 22f. DATE SIGNED<br><b>5/8/84</b>   |  |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b> | 23b. DATE<br><b>5-9-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SINAI Hospital</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SINAI Hospital</b>            |                            | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>          |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>              |                            |   |   |



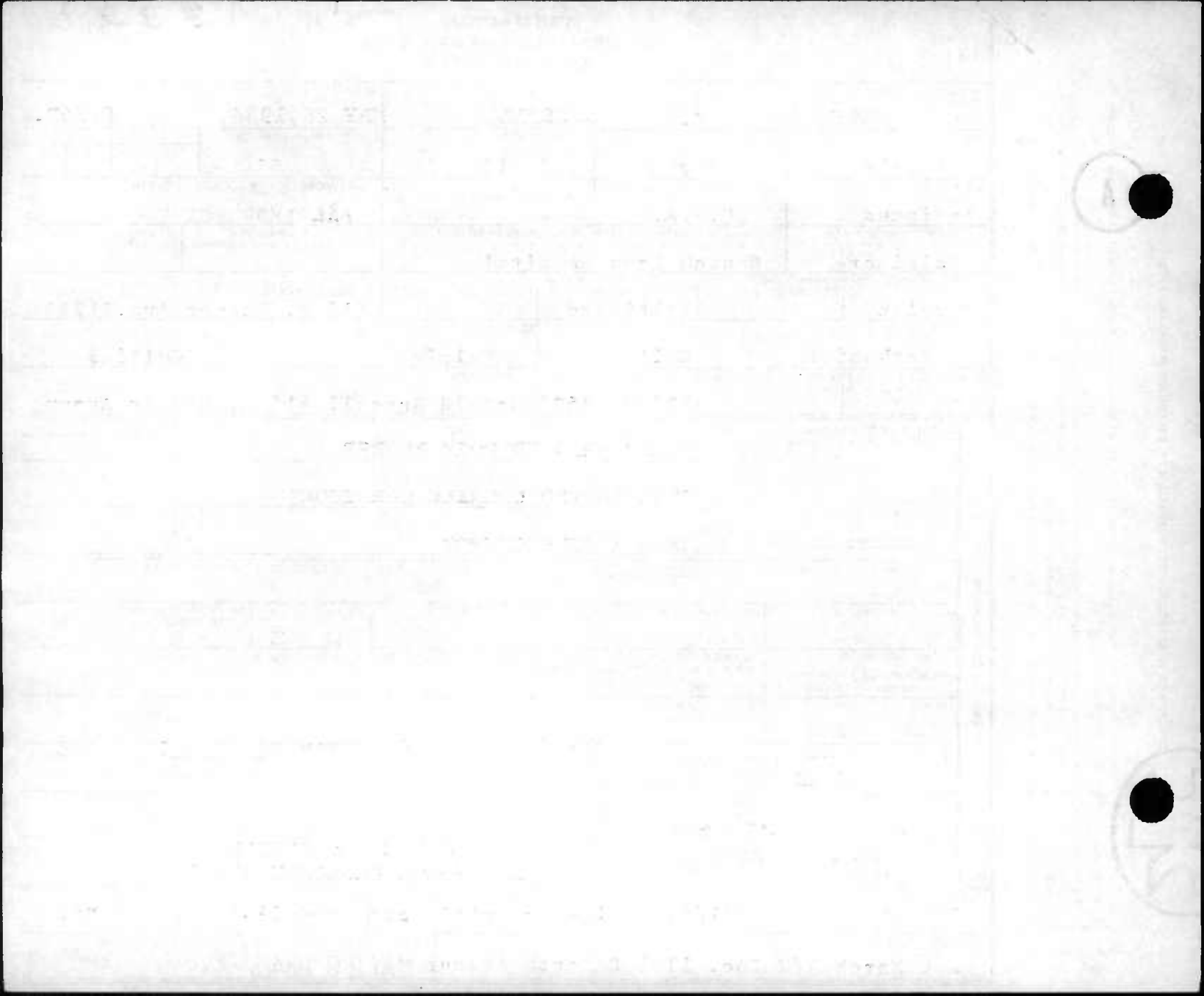
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA B. RUSSELL</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 26, 1984</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 15 29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nathaniel Bell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Valpie Collins</b>   |  | 17. INFORMANT ADDRESS<br><b>Donald Russell 615 N. Radnor Avenue</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>309-30-3525</b>   |  | 17. INFORMANT ADDRESS<br><b>Donald Russell 615 N. Radnor Avenue</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1790</b> IMMEDIATE CAUSE (a) <b>CARDIO -RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DISSEMINATED UTERINE CARCINOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>RENAL INSUFFICIENCY</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>MAY 23 84</b> to <b>MAY 26 84</b> , that (I) (we) last saw the deceased on <b>MAY 26 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Bruce Kinosian</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>5/26/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRUCE KINOSIAN</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 NORTH BROADWAY 21231</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/31/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in line by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |   |   |  |
|--|--|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JESSIE R. RUSSELL</b>  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 29TH, 1984</b>           |  |   | 2b. HOUR A<br><b>4:20 M</b>   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 9, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |   |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Timonium,</b>                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>1201 Doragen Ct. 21093</b>  |  |  |   |   |  |  |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry J. Hoeck</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jessie Mardaga</b> |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES, GIVE WAR OR DATES<br><b>No</b>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>220-48-8665</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>C. Edmund Russell - Same as #13e</b>     |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Cancer</b>  |  |  |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> 19 <b>84</b> to <b>5/29</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>George D. Bitter</b><br>DEGREE<br><b>M.D.</b>   |  |  |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/29/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George D. Bitter</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO .MD.<br/>% Johns Hopkins Hosp. 21205</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>5-30-84</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |  |

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

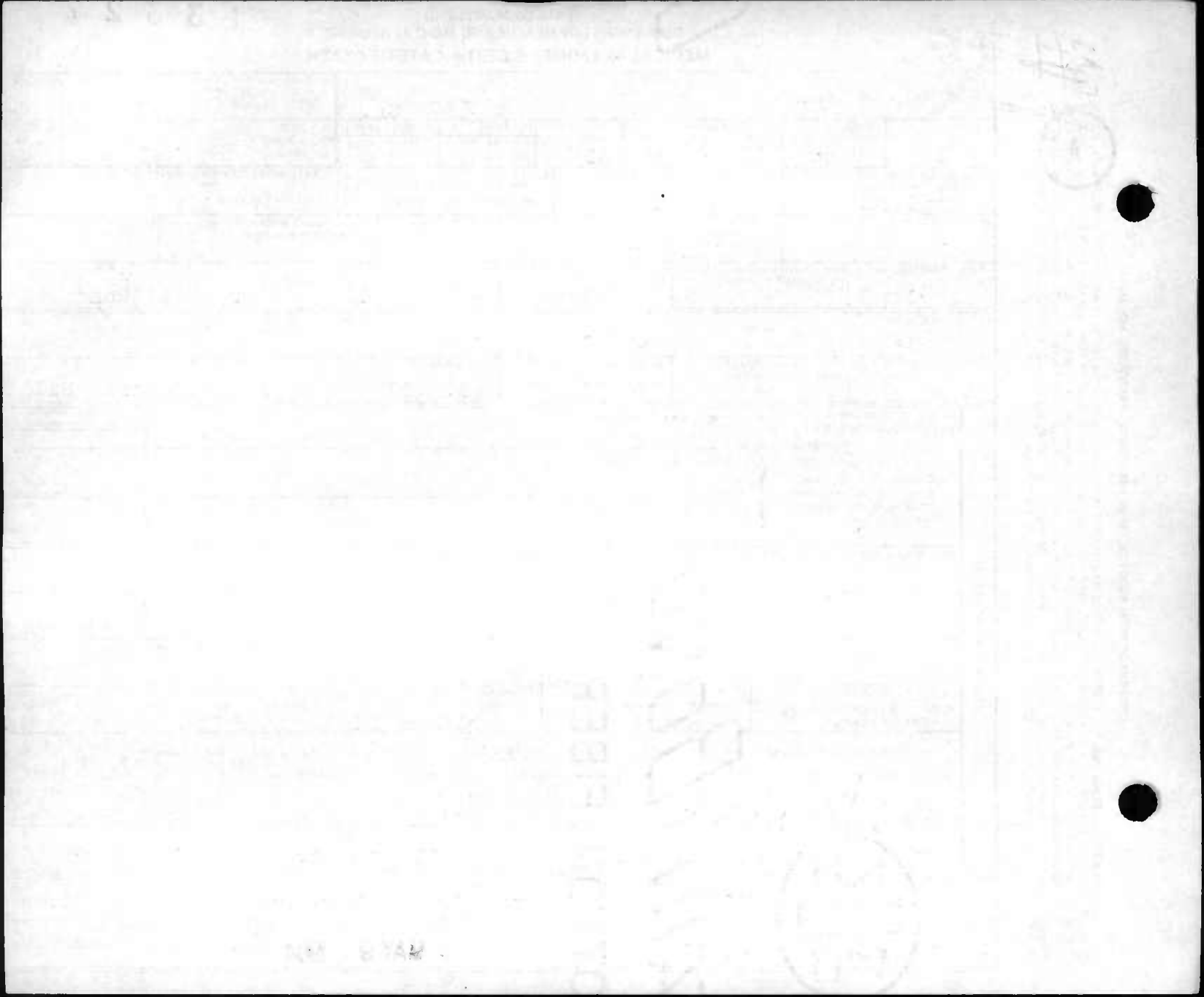
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                              |   |  |   |                                      |  |  |
|--|------------------------------|---|--|---|--------------------------------------|--|--|
| 1- FOR STATE REGISTRAR   |                              | 2a. DATE KNOWN OF DEATH   |  | MONTH DAY YEAR  |                                      | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |                              | FIRST MIDDLE LAST   |  | 2a. DATE KNOWN OF DEATH   |                                      | 2b. HOUR   |  |
| MARCUS V. RUSSELL Sr.  |                              |   |  | 5 7 19 84   |                                      | M  |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.                     | 7c. DATE PRONOUNCED DEAD   | 7d. HOUR                                     |
| male   | Black                        | MONTH DAY YEAR  | LAST BIRTHDAY  | MONTHS DAYS   | HOURS MIN.                           | 5 7 19 84  | 9:25 PM                                      |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| Maryland   | U.S.A.                       |   |  |   | Baltimore City MD.                   |  |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                                      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Baltimore  |                              | 200 Blk. Reedbird Ave.  |  |   |                                      |  |  |
| 13a. STATE   |                              | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                                      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland   |                              |   |  | Baltimore   |                                      |  |  |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)            |                                      | 16b. SOCIAL SECURITY NO.   |  |
| Isaiah   |                              | Inez  |  | Yes   |                                      | 220-56-0031  |  |
| 17. INFORMANT  |                              | ADDRESS   |  | 17. INFORMANT ADDRESS   |                                      |  |  |
| Michelle Russell   |                              | 1004 Cherry Hill  |  | 1004 Cherry Hill  |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |   |  |   |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:  |                              |   |  |   |                                      |  |  |
| IMMEDIATE CAUSE (a) Gunshot wound of chest (unspecified weapon)  |                              |   |  |   |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |   |  |   |                                      |  |  |
| (b)  |                              |   |  |   |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |   |  |   |                                      |  |  |
| (c)  |                              |   |  |   |                                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |   |  |   |                                      |  |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                                      | 20. AUTOPSY?   |  |
|  |                              |   |  |   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |  |  |
|  |                              | 9 P.M. 5-7- 1984  |  | Subject was shot.   |                                      |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION   |                                      |  |  |
|  |                              | rear of   |  | 200 blk. Reedbird Ave., Balto. City Md.                                       |                                      |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                              |   |  |   |                                      |  |  |
| ACTUAL SIGNATURE   |                              | TITLE (SPECIFY)   |  | DATE SIGNED   |                                      |  |  |
| Ann M. Dixon   |                              | M.D. Assistant MEDICAL EXAMINER   |  | 5-8-84  |                                      |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |                              | ADDRESS   |  |   |                                      |  |  |
| Ann M. Dixon, M.D.   |                              | 111 Penn St., Balto., Md.   |  | 21201   |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      | 23d. LOCATION  |  |
| BURIAL   |                              | 5/11/84   |  | Md. Veteran Cem.  |                                      | Crownsville, Md.   |  |
| 24. FUNERAL DIRECTOR   |                              | NAME  |  | ADDRESS   |                                      | 25a. DATE REC'D. BY REGISTRAR  |  |
| Wm C March F/H Inc.  |                              | 1101 E North Avenue   |  | MAY 9 1984  |                                      | 25b. REGISTRAR'S SIGNATURE   |  |
|  |                              |   |  |   |                                      | Julia Davidson-Randall   |  |



BP \_\_\_\_\_  
DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Stella B. Russell</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>29</b> YEAR <b>1984</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>10</b> YEAR <b>1898</b>   |  | 2b. HOUR<br><b>10:45 P.M.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kennestone Nursing Center</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Neaf</b>  |  |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>B</b> LAST <b>Russell</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lee</b> MIDDLE <b>—</b> LAST <b>Mills</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-05-8718</b>   |  |
| 17. INFORMANT<br><b>Geo. W. Barrett, Jr.</b>  |  | ADDRESS<br><b>4122 Kahlston Rd.</b>   |  | 17. INFORMANT<br><b>Balto., Md. 21236</b>   |  | 17. INFORMANT<br><b>Balto., Md. 21236</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4850</b> IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio Sclerotic Heart Disease</b><br><b>Generalized Arterio Sclerosis</b> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>24 hrs</b><br><b>5 yrs</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Generalized Arterio Sclerosis</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>—</b> <b>—</b> <b>—</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br><b>—</b>   |  | 21g. CITY OR TOWN<br><b>—</b>   |  | 21h. COUNTY<br><b>—</b>  |  |
| 21i. STATE<br><b>—</b>  |  | 21j. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1965</b> to <b>May 27, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 27, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  | 21k. SIGNATURE<br><b>Earl L. Chambers M.D.</b>  |  | 21l. DATE SIGNED<br><b>5/29/84</b>   |  |
| 21m. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Earl Chambers, MD. (235-0634)</b>   |  | 21n. ADDRESS<br><b>9 Charlcote Place Balto., Md.</b>  |  | 21o. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                        |  | 21p. DATE SIGNED<br><b>5/29/84</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-31-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>—</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lacich F. H. Balto. Md. 21236</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>—</b>   |  |

Handwritten notes in the left margin, possibly including a date or reference number.

Main body of handwritten text, appearing to be a letter or report, written in cursive script.



Continuation of handwritten text at the bottom of the page, possibly a signature or closing.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO. 13324                               |  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>SAMUEL J. ACOB SACHS   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>05 16 84 |  |  | 2b. HOUR<br>11:54 PM   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 29 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>APT. 3A<br>2 DEAUVILLE CT. #21208   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARRY SACHS   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>REBECCA COHEN   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212 32 0657   |  | 17. INFORMANT BERNARD J. SACHS 7th FL.<br>111 N. CHARLES ST. BALTO., MD 21201   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 CARDIO PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>HYPERTENSION, ASCVD |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>R. W. Braxton  |  |   |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED<br>5/17/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK W. BRAXTON  |  |   |  | 22e. ADDRESS<br>North Pkwy at Greenspring - Balt MD   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MAY 18, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Hendall  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |   |  |  |  |  |  |

100-4414

JOHN LEVINGTON & SONS



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 calendar days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 38 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13325

|   |  |   |   |                                      |          |
|---|--|---|---|--------------------------------------|----------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 20. DATE OF DEATH   |   | 21. HOUR                             |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 20. DATE OF DEATH   |   | 21. HOUR                             |          |
| Alvin J. Sadler   |  | 5 15 84   |   | 1:01pM                               |          |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. BALTIMORE CITY OR COUNTY OF DEATH |          |
| Male  | Caucasian  | 7 31 38   | 45 YRS.   | Baltimore City MD.                   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                      |          |
| Maryland  | USA  |   | Baltimore City  |                                      |          |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                      |          |
| Baltimore, Md.  | Baltimore City Hospital 21224  | Disabled  |   |                                      |          |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                  |          |
| Maryland  | Baltimore  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 21217 1600 Mount Royal Terrace       |          |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |                                      |          |
| Raymond   | Viola Jeffery  | No  |   |                                      |          |
| 16a. SOCIAL SECURITY NO.  | 17. INFORMANT  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |                                      |          |
| 217-34-6964   | Mrs. Susan Hitt 1600 Mount Royal Terrace   | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal failure in hemodialysis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetis Mellitus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>2 years</u> |   |                                      |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |                                      |          |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |          |
| N/A   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                      |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                                      |          |
|   | HOUR A.M. MONTH DAY YEAR   |   |   |                                      |          |
|   | P.M. 19  |   |   |                                      |          |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION   |   |                                      |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | CITY OR TOWN COUNTY STATE   |   |                                      |          |
| 22a. I certify that (I) (this hospital) attended the deceased from May 15, 1984, to May 15, 1984, that (I) (we) lost saw the deceased alive on May 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |                                      |          |
| 22b. SIGNATURE  | DEGREE   | 22c. DATE SIGNED  |   |                                      |          |
| J. B. Zachary, M.D.   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 5/15/84   |   |                                      |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |   |   |                                      |          |
| J. B. Zachary, M.D.   | Baltimore City Hospital  |   |   |                                      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION   | COUNTY                               | STATE    |
| Cremation   | 5/18/84  | Greenmount Cem.   | Baltimore   |                                      | Maryland |
| 24. FUNERAL DIRECTOR  | 25. DATE REC'D. BY REGISTRAR   |   | 25. REGISTRAR'S SIGNATURE   |                                      |          |
| A. Alan Seitz, Jr.  | MAY 22 1984  |   | John Davidson   |                                      |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO.   |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CURTIS M. SAMPLE</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>8</b> YEAR <b>84</b> 2b. HOUR <b>11:55P</b> |   |  |  |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>15</b> YEAR <b>30</b>  |  | 6. AGE (IN YEARS)<br><b>53</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>53</b> DAYS <b>53</b> HOURS <b>53</b> MIN. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN)<br><b>Balto., MD</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD   |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hosp.</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>            |  | 15. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2439 Callow Ave. 21217</b>            |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Sample</b> LAST <b>Sample</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Marie</b> MIDDLE <b>Davis</b> LAST <b>Davis</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-1444-A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Martha Sample 2439 Callow Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MALNUTRITION, SEPSIS, HYPERCALCEMIA</b><br>1619<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LARYNGEAL CANCER (squamous cells)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>5-6-1984</b> 19, to <b>5-8-1984</b> 19, that (we) last saw the deceased alive on <b>5-8-1984</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Francis J. Khoo</b>   |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>5-8-84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANCIS KHOO</b>   |  |  |  | 22e. ADDRESS<br><b>University of Maryland Cancer Center</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/14/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> STATE                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. Brown Comm F/H</b>  |  |  |  | ADDRESS<br><b>1206-03 W. North Ave.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1984</b>  |  |  |  |
|  |  |  |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

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MANIFESTATION, SEVERE, HYPERCALCAEMIA

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University of Maryland Cancer Center

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 84 13327   |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH  |   |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>CARL E. Sappington  |  |  |  |   | MONTH DAY YEAR<br>May 31, 1984   |   |   | 11:51 A.M.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | 7. IF UNDER 1 YEAR   |  |
| MALE   |  | WHITE  |  | MONTH DAY YEAR<br>May 7 1964  |  | 67 YRS.   |   | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |  |
| WASHINGTON, D.C.   |  | USA  |  |   |  | BALTIMORE CITY MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE, CITY  |  | UNION MEMORIAL HOSPITAL  |  |   |  | BAR MANAGER   |   | J.J.C. Inc.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS / ZIP CODE  |  |  |
| 13a. STATE MIDDLE LAST<br>MARYLAND   |  |  |  |   | 13b. COUNTY<br>BALTIMORE   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>3009 Shannon Drive 21213 |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Howard E. Sappington, Sr.   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mamie Lutz                       |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  |  |  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW 11                  |   | 17. INFORMANT ADDRESS<br>3009 Shannon Dr. Baltimore, Md. 21213                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>3491 IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>anoxic encephalopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>seizure disorder</u>   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>31r multiple pneumonias  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 29</u> 19 <u>84</u> to <u>May 31</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>May 31</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Victoria A. Vanik  |  |  |  |   | DEGREE<br>MD   |   |   | 22c. DATE SIGNED<br>May 31, 1984                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VICTORIA A. VANIK   |  |  |  |   | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>6-4-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LASSAHN FUNERAL Home   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 4 1984                                    |   | 25b. REGISTRAR'S SIGNATURE<br>Jana Davidson-Randall   |  |  |

A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |                             |   |  |
|--|--|--|---|---|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Clara E. Sauer</i> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>05 05 84</i> |   | 2b. HOUR<br><i>10:30 AM</i> |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>09 17 96</i>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>87</i> YRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Balto. Gen. Hosp.</i>  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Cleaning Lady</i>  |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>B. &amp; O R.R.</i>                                     |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>---</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Unknown</i>                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Unknown</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>  |                             | 16b. SOCIAL SECURITY NO.<br><i>214-18-5939</i>  |  |
| 17. INFORMANT ADDRESS<br><i>Mr. Walter A. Tyson, Same as above</i>             |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>5715 Pulmonary edema + bronchopneumonia</i><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br><i>Liver cirrhosis, MICRONODULAR</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |   |  |

## MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Severe generalized arteriosclerosis.*

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>05/05</i> , 19 <i>84</i> , to <i>05/05</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>05/05</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE <i>J. Soler / M. KUCAS</i> DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>05/05/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>J. Soler / M. KUCAS</i>   |  |   |  | 22e. ADDRESS<br><i>3001 S. HANOVER ST., BALT., MD.</i>   |  |  |  |

|   |  |                                 |  |  |  |   |  |
|---|--|---------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                  |  | 23b. DATE<br><i>May 9, 1984</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i> |  |
| 24. FUNERAL DIRECTOR NAME<br><i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21203</i> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 7 1984</i>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. H. Davidson</i>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/B2  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Bernadine P. sauls  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 11 84  |  | 2b. HOUR<br>527 PM   |
| 3. SEX<br>Female   | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 16 44   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Cty. Balto. MD.                              |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sina. Hosp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSE WIFE       | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |  |  |
| 13a. STATE<br>md.  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3815 Hay ward Ave.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERNARD J. SNEAD SR.   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CHRISTINE SANDERS  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br>MARIE SIVELS 6800 Liberty Rd                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>asystole of U-tach</u><br>4/100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute MI</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Malignant hypertension</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>40 min<br>chronic |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>(12) putamen hemorrhage.</u>  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>84</u> , to <u>5/11</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>5/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br>Edward Zimmerman MD  |   | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/11/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edward Zimmerman  |   | 22e. ADDRESS<br>Sina. Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |   | 23b. DATE<br>5/16/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus men Park                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chatman Harris   |   | ADDRESS<br>FA 1701 McCulloh St.   |  | 25. DATE RECEIVED BY MEDICAL EXAMINER<br>MAY 17 1984                                 |  |



11  
The following is a list of the plants  
which have been introduced into the  
United States from other countries  
since the year 1800. The list is  
given in alphabetical order of the  
names of the plants. The names of  
the countries from which the plants  
were introduced are given in  
parentheses. The names of the  
persons who introduced the plants  
are given in brackets. The names of  
the persons who have since  
introduced the plants are given in  
italics. The names of the persons  
who have since introduced the plants  
are given in italics. The names of  
the persons who have since introduced  
the plants are given in italics.

PLANT INDUSTRY

BOX 30101

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|------------------|--|--|--|--------------------|--|
| 1- FOR STATE REGISTRAR   |  |                  |  |   |  |   |  |   |  | REG. NO.  |  |   |  |   |  |                  |  |  |  |                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Michael R. Savoy   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR 5-18 19 84                   |  |   |  |   |  |                  |  |  |  | 2b. HOUR<br>M 3:18 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 6 25 1956  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) 27 YRS.                                      |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>5-18 19 84                      |  |   |  | 2d. HOUR<br>a. M |  |  |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Hawaii  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |   |  |                  |  |  |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security Guard   |  |   |  | 12b. KIND OF BUSINESS<br>Liberty Security                   |  |   |  |                  |  |  |  |                    |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>8 Slate Mills Court<br>Catonsville, Maryland 21228 |  |   |  |   |  |                  |  |  |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vernon J. Savoy  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha E. Washington             |  |   |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) Yes  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>218-58-6905   |  | 17. INFORMANT<br>Martha E. Savoy 8 Slate Mills Court<br>Baltimore, Maryland 21228 |  |   |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Stab Wound of Chest<br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |                  |  |   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                  |  |  |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |  |  |                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 5-18 19 84  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was stabbed  |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>?  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>? Baltimore, Maryland  |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.  |  |                  |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | DATE SIGNED<br>5-18-84  |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |   |  |   |  |   |  |                  |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial  |  |                  |  | 23b. DATE<br>5/22/1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland         |  |   |  |   |  |                  |  |  |  |                    |  |
| 24. FUNERAL DIRECTOR<br>NAME Nutter & Sons Funeral Home Inc.<br>2501 Gwynns Falls Pkwy. Baltimore, Md. 21228   |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1984  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |   |  |                  |  |  |  |                    |  |

4

into place 6 25 1945

U. S. A.

Security Guard  
State Police  
Camden, Maryland 21225

X

Baltimore

Maryland

Washington  
State Police  
Baltimore, Maryland 21225

Watts

Savoy

J.

Person

Martha E. Savoy Baltimore, Maryland 21225

212-58-4521

Yes

Baltimore, Maryland

Martha E. Savoy Baltimore, Maryland 21225

2001 to year 2010 (approx. 10 years)  
Baltimore, Md. 21225

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 3 1

1- STATE REGISTRAR

REG. NO.

|   |  |  |  |  |                         |   |  |
|---|--|--|--|--|-------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GERTRUDE C. SAYLOR</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-26-84</b> |  | 2b. HOUR<br><b>5A-M</b> |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3-10-1913</b>  |                         | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>71</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2817 HARVIEW AVE.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERICAL</b>   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FORTRESS PRESS</b>  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>—</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>2817 HARVIEW AVE.</b>   |  | 13f. STREET ADDRESS<br><b>21234</b>  |  | 13g. STREET ADDRESS<br><b>21234</b>  |                         | 13h. STREET ADDRESS<br><b>21234</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HENRY GROSS</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>WILHELMINA STEINER</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>220-07-1579A</b>   |  |
| 17. INFORMANT ADDRESS<br><b>Mrs. Helen Gross - 2817 Harview Ave.</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Helen Gross - 2817 Harview Ave.</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Helen Gross - 2817 Harview Ave.</b>   |                         | 17. INFORMANT ADDRESS<br><b>Mrs. Helen Gross - 2817 Harview Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749 IMMEDIATE CAUSE (a) Malignant breast cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~1 year</b>                    |  |  |  |  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~1 year</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |                         |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                         | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE   |                         | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 19 84</b> to <b>May 26 19 84</b> , that (I) (we) last saw the deceased alive on <b>April 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                         |   |  |
| 22b. SIGNATURE<br><b>Paul Chang, MD</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                         | 22c. DATE SIGNED<br><b>5/26/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Chang, MD</b>  |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd, Baltimore, MD 21239</b>   |  | 22f. ADDRESS<br><b>5601 Loch Raven Blvd, Baltimore, MD 21239</b>   |                         | 22g. ADDRESS<br><b>5601 Loch Raven Blvd, Baltimore, MD 21239</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAY 29, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b>   |                         | 23d. LOCATION CITY OR TOWN COUNTY<br><b>PARKVILLE BALTIMORE MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HARTLEY MILLER</b>  |  | 24. FUNERAL DIRECTOR ADDRESS<br><b>7527 HARFORD RD</b>   |  | 25a. DATE RECEIVED BY REGISTRY<br><b>MAY 28 1984</b>   |                         | 25b. REGISTRAR'S SIGNATURE  |  |



Handwritten notes and scribbles, including the word "HAY" and various illegible markings.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

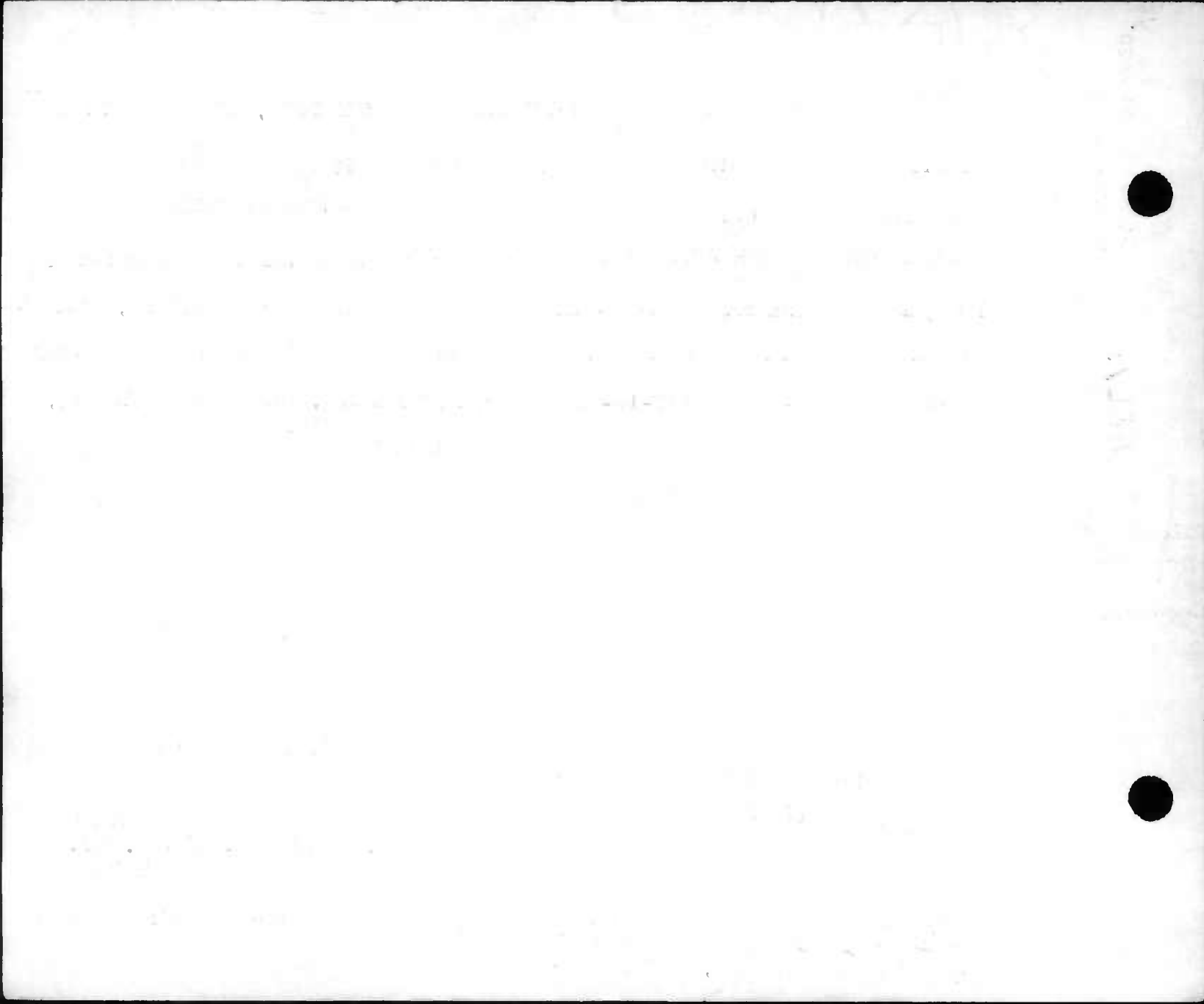
|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>EDWARD Philip SCHAEFER   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 28TH, 1984  |  | 2b. HOUR<br>3:09 M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 25 1924   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>59  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Accounting   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Cockeysville   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Louis P. Schaefer, Sr.   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edith Virginia McElroy  |  | 13e. STREET ADDRESS / ZIP CODE<br>10607 Blue Bell Way, 21030  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-16-4284   |  | 17. INFORMANT ADDRESS<br>Mary A. Schaefer, 10607 Blue Bell Way, 21030   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>1629 IMMEDIATE CAUSE (a) <u>Cardio - Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic adenocarcinoma of the lung</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min. 3 months |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/25 84 to 5/28 84, that (1) (we) lost saw the deceased alive on 5/28 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Dm R. Martin MD   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>5/28/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dm R. Martin MD  |  | 22e. ADDRESS<br>John Hopkins Hospital 21205   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK)<br>Burial   |  | 23b. DATE<br>5/30/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mausoleum  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Timonium Balto. Md.  |  |
| 24. FUNERAL DIRECTOR<br>J. E. Lowell Lemmon   |  | ADDRESS<br>10 W. Padonia Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 31 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>J. E. Lowell Lemmon   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial form 1 permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked below, any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |   |   |
|---|--|---|--|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Katherine --- Schaffer</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 06 84</b>                      |   | 2b. HOUR<br><b>7<sup>25</sup> A.M.</b> |   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 20 89</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>94</b>                                |  | 7. IF UNDER 1 YEAR<br>IF UNDER 74 HRS.<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital Balto. Md.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1752 S. Hanover St. Balto. Md. 2120</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bernard --- Kamphaus</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline --- Steuve</b> |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-30-9510</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mary K. Simon, Same as above</b>  |   |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>5741</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>cholecystitis / cholelithiasis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)<br><b>congestive heart failure</b> |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>days</b><br><b>days</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>4-27</b> , 19 <b>84</b> , to <b>5-6</b> , 19 <b>84</b> , that (we) most saw the deceased alive on <b>5-6</b> , 19 <b>84</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death.  |  |   |  |   |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Jeanne L. Saunders MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br><b>5-6-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeanne L. Saunders</b>  |  |   |  | 22e. ADDRESS<br><b>301 St. Paul Place</b>   |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 9, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |   |   |

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20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

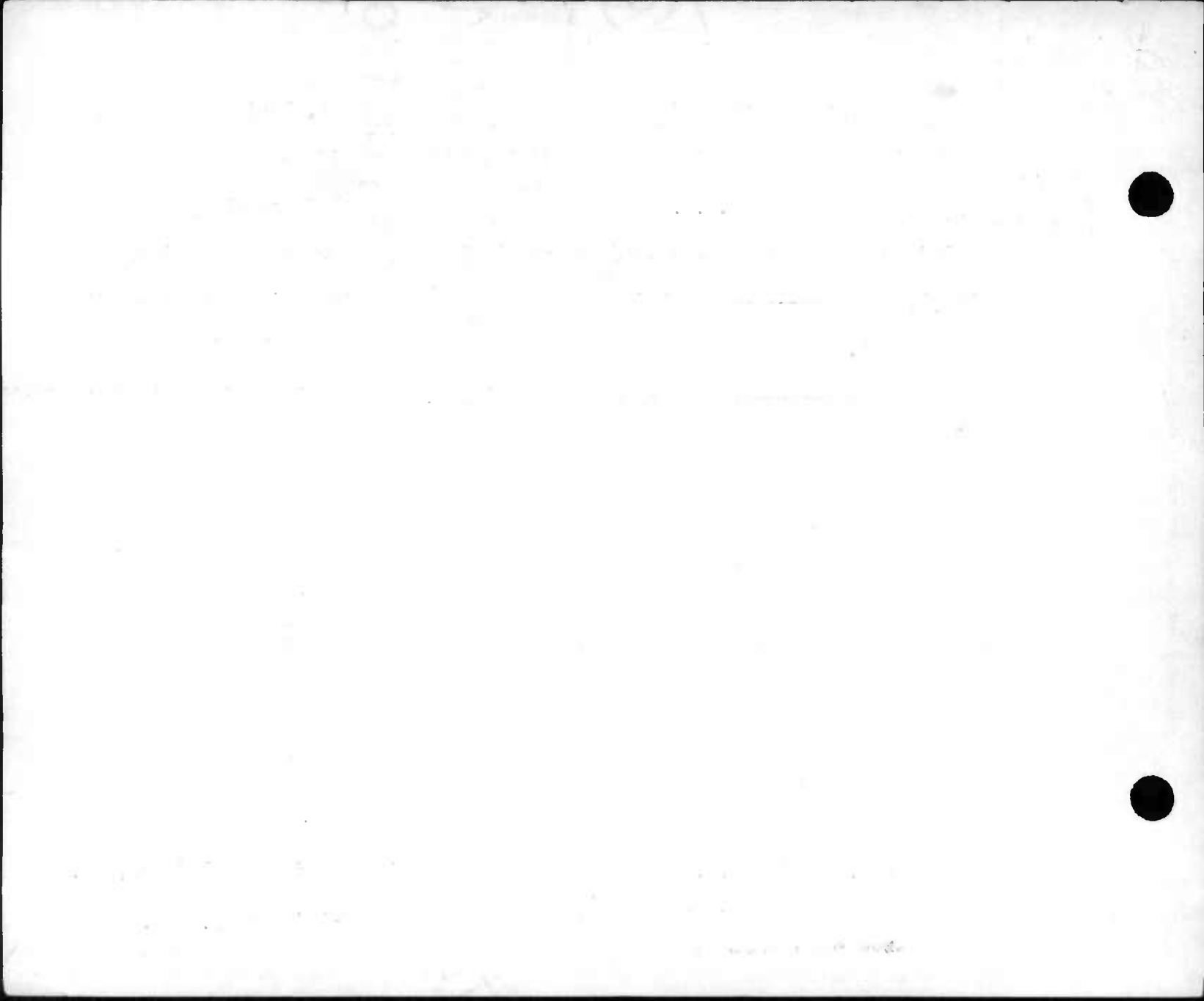
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dorothy Catherine SCHAUM  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 2, 1984  |  | 2b. HOUR<br>5:00A M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 12, 1924  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4435 Springwood Avenue 21206 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Funeral   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>-----  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4435 Springwood Avenue 21206   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony S. Gutowski   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Palagia Kovalleski   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>218-12-6421   |   | 17. INFORMANT<br>ADDRESS<br>Charles A. Schaum 4435 Springwood Avenue 21206           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Esophageal cancer</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Susan R. Lessin, M.D.</u> DEGREE   |   |   |   | 22c. DATE SIGNED<br>May 2, 1984  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Susan R. Lessin, M.D.  |   |   |   | 22e. ADDRESS<br>Johns Hopkins Hospital Baltimore, Md.                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>May 5, 1984  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Doppel Funeral Homes, Inc.  |   | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1984  |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Burden</u>                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT</b> <b>SCHERMAN</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05-29-84</b>  |  | 2b. HOUR<br><b>9<sup>15</sup> A.M.</b>   |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 15, 1894</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>88</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANT</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>3908 FALLSTAFF RD. #21215</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>REUBIN SHERMAN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHEL UNKNOWN</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-32-1611</b>   |  | 17. INFORMANT<br><b>MRS. SYLVIA KESNER</b> APT. D<br><b>4612 DEBILEN CIR. BALTO., MD</b> 21208  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ISCHEMIC HEART DISEASE</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA OF THE COLON</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CARCINOMA OF THE COLON</b>  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>04-12</b> 19 <b>84</b> to <b>05-29</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>05-29</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>H. HARRIS MD</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>5-29-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAW-WIN, MD</b>  |  | 22e. ADDRESS<br><b>LEVINDALE GERIATRIC GR</b> BALTO. 21215  |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAY 30, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH HAMEDROSH HAGODOL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sylvia Davidson-Randall</b>   |   |

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RECEIVED  
JAN 10 1964

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TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

RECEIVED  
JAN 10 1964  
[illegible text follows]

REG. NO.

|  |   |  |         |
|--|---|--|---------|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Thomas Schue, Sr.     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mathilda Pfeiffer |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) | 17. INFORMANT  | ADDRESS |
| No   | 217 38 0845   | Mrs. Amy C. Scheu,   | Same    |

| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|
| PART I. DEATH WAS CAUSED BY:  | Probable Acute myocardial infarction         |   |
| 4100 IMMEDIATE CAUSE (a)  | Hemorrhage into atherosclerotic plaque       |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | (b) Left anterior descending coronary artery |   |
|   | (c) DUE TO, OR AS A CONSEQUENCE OF           |   |

|               |   |  |  |   |
|---------------|---|--|--|---|
| CERTIFICATION | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Congestive heart failure, Severe atherosclerosis, Abdominal aortic aneurysm</i> |  |  |   |
|               | 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

|                     |  |  |  |  |  |  |
|---------------------|--|--|--|--|--|--|
| MEDICAL CERTIFICATE | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
|                     | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

22a I certify that (it) (this hospital) attended the deceased from 4/30, 1984, to 5/1, 1984, that (it) (we) last saw the deceased alive on 5/1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.

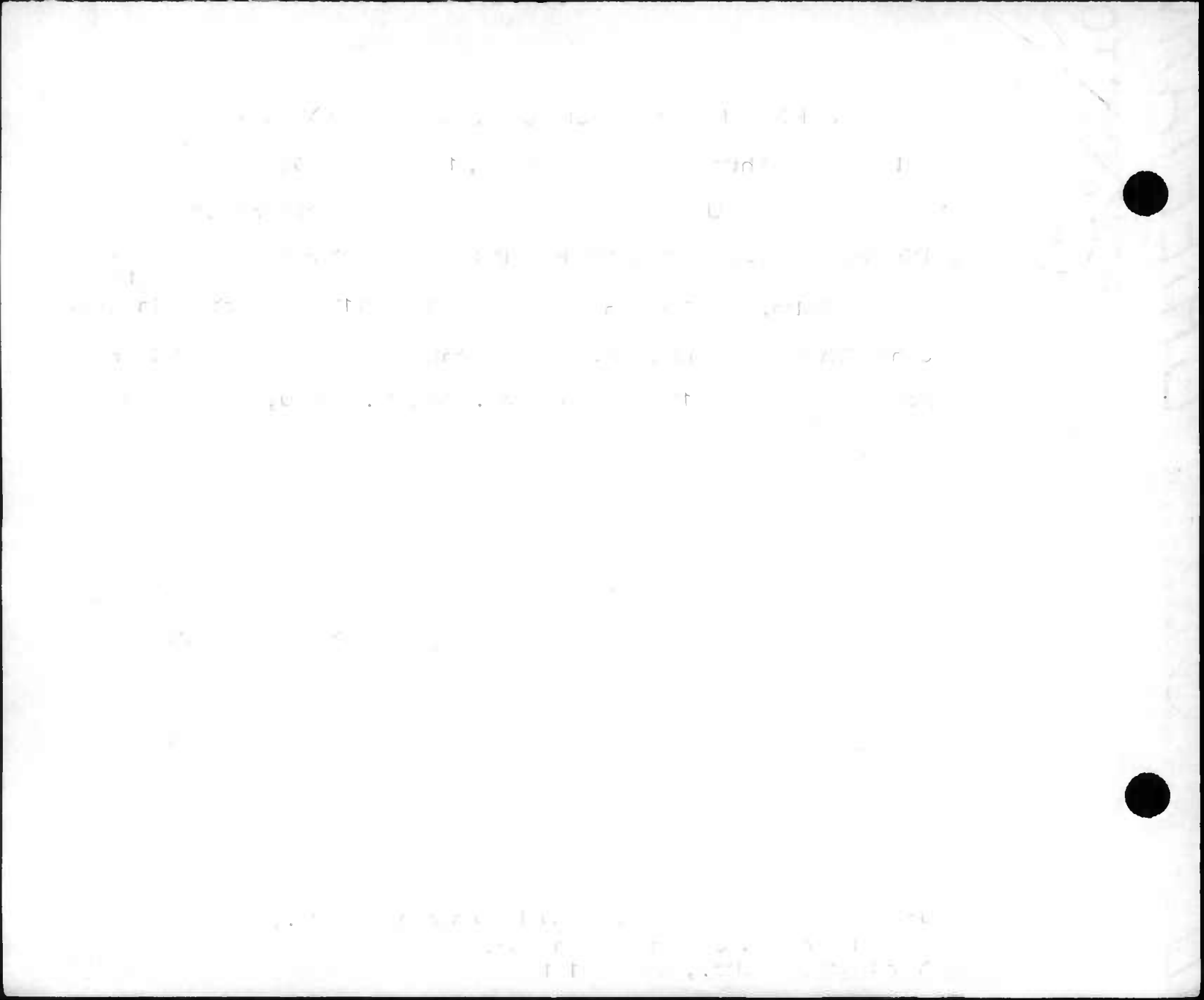
|   |        |   |  |  |                                   |
|---|--------|---|--|--|-----------------------------------|
| 22b. SIGNATURE<br><i>Mario Littman MD</i> | DEGREE | ATTENDING<br>PHYSICIAN <input type="checkbox"/> | MEDICAL<br>DIRECTOR <input type="checkbox"/> | STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><i>5/1/84</i> |
|---|--------|---|--|--|-----------------------------------|

|                                       |                                     |
|---------------------------------------|-------------------------------------|
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) | 27e. ADDRESS                        |
| Mario Littman                         | 5601 Loch Raven Blvd Balt, MD 21212 |

|  |                     |   |  |        |             |
|--|---------------------|---|--|--------|-------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>5/3/84 | 23c. NAME OF CEMETERY OR CREMATORY<br>Immanuel Lutheran | 23d. LOCATION<br>CITY OR TOWN<br>Balto.. | COUNTY | STATE<br>MD |
|--|---------------------|---|--|--------|-------------|

|                                 |                             |                             |                           |
|---------------------------------|-----------------------------|-----------------------------|---------------------------|
| 24 FUNERAL DIRECTOR<br>NAME     | Henry W. Jenkins & Sons Co. | 25a DATE REC'D BY REGISTRAR | 25b REGISTRAR'S SIGNATURE |
| 4905 York Road Balto., MD 21212 |                             | MAY 4 1984                  | Julia Davidson-Randall    |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

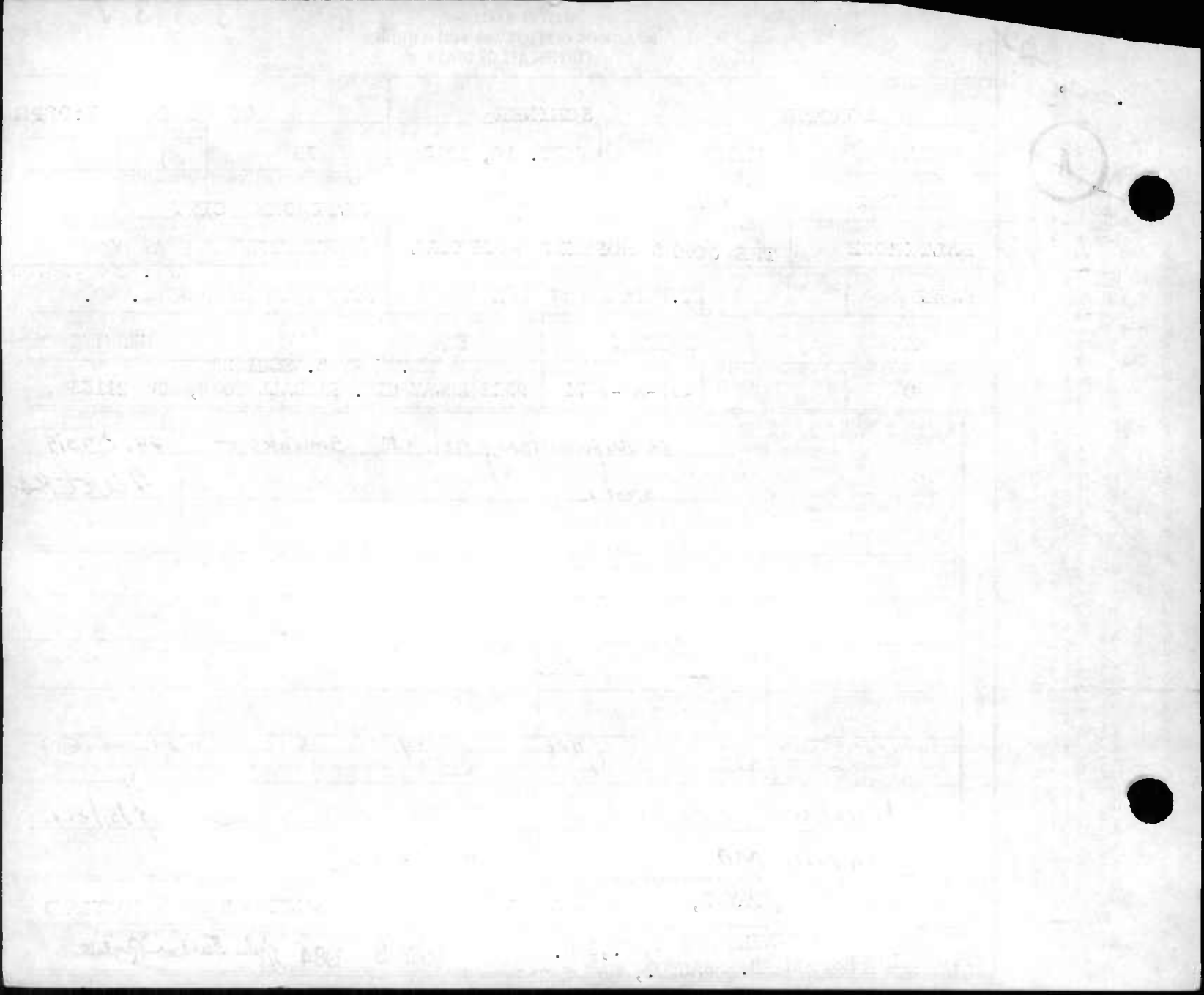
|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY SCHINER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 05 84</b>                 |   |  | 2b. HOUR<br><b>7:08PM</b>  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 10, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>FLORIDA</b>  |  |  |  |   | 13b. COUNTY<br><b>ST. PETERSBURG</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX KURITZKY</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA HURWITZ</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>057-20-5471</b>                         |   | 17. INFORMANT <b>MR. KENT E. SCHINER</b><br><b>9322 EDWAY CIR. RANDALLSTOWN, MD 21133</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest 5 minutes -</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>stroke</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>645 PM 5/5</b><br><b>2 WEEKS</b> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/21</b> <b>19 84</b> to <b>5/5</b> <b>19 84</b> , that (I) (we) lost saw the deceased alive on <b>5/5</b> <b>19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.   |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>E. Smeeten</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/5/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E Smeeten MD</b>   |  |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>MAY 7, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>   |  |   |  |  |
|  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 is marked, the medical examiner must be notified of this.

999999



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Cardine Schirmer   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5. 7. 84  |  | 2b. HOUR<br>6 <sup>30</sup> AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 - 13 - 99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nrsng Center-Hamilton |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Home Maker   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2409 Hamilton Ave.-21214   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Adam Schmitt   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Schmittle  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-09-8832<br>213-74-6831   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Michael J. Schirmer-4335 Berger Ace. 21206  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) Sideroblastic Anemia   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Debut, two wks  |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Contrahine secondary to childbirth  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1, 19 84, to May 7, 19 84, that (I) (we) lost saw the deceased alive on Apr 24, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Howard H Bond MD   |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5/7/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Howard H Bond MD  |  | 22e. ADDRESS<br>9618 Belair Rd Baltimore Md   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>5-10-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Rd.-21206   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Balto. Md.

U.S.A.

Home 1600

2409 Hamilton Ave. - 21214

x

Balto.

Md.

Adam Schmitt

Agnes Schmitt

21205

213-74-6831 Mr. Michael J. Schinner-4337 Berger Ave.

216-07-8832



Balto. Md.

Holy Redeemer Cemetery

7-8-81

Burial

John C. Miller Inc-6415 Belair Rd. - 21205

00 4 1 3 3 3 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

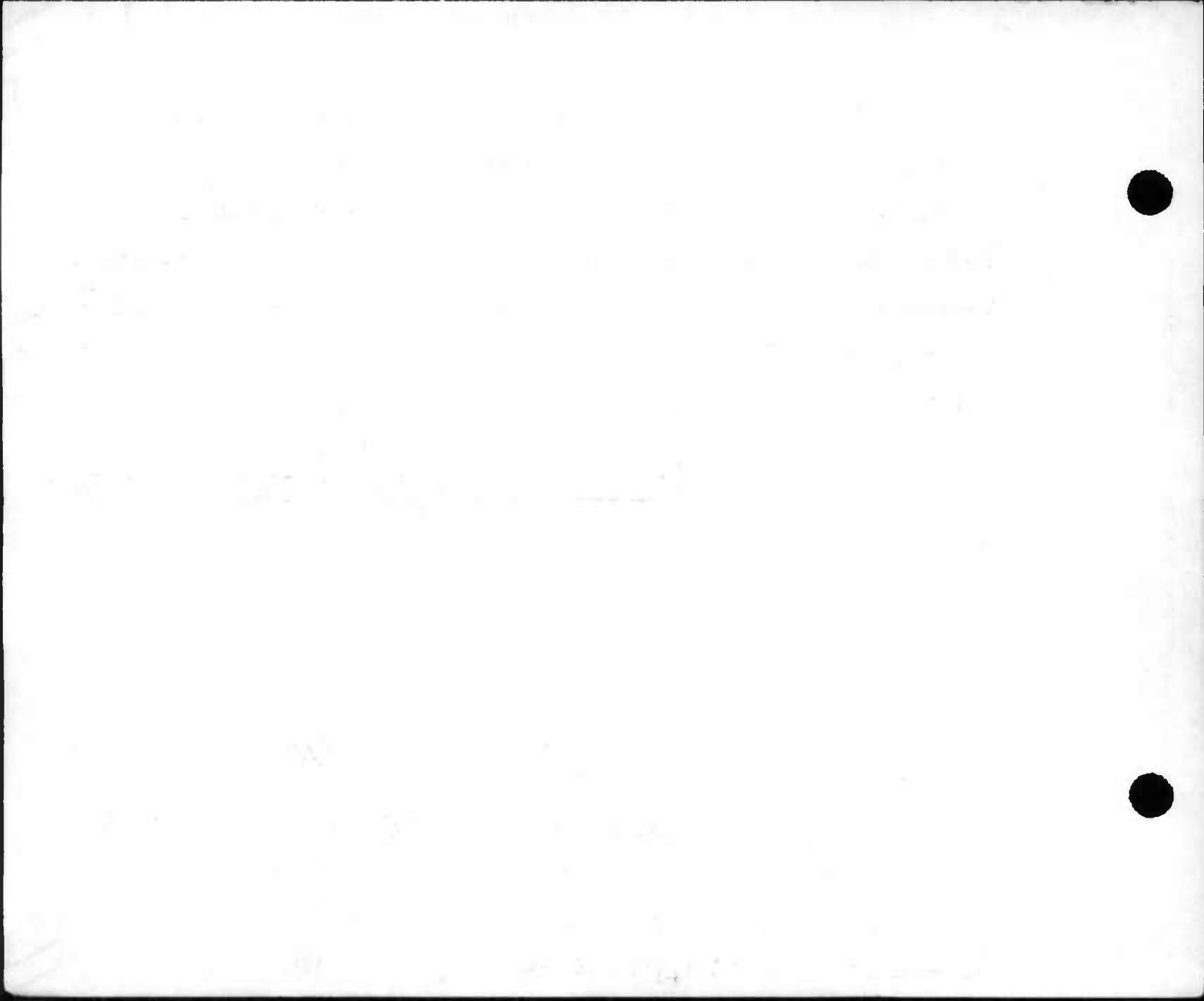
|   |  |  |  |  |  |   |  |                                |  |
|---|--|--|--|--|--|---|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 26. DATE OF DEATH  |  | MONTH YEAR  |  | 26. HOUR                       |  |
| HILBERT M. SCHIRMER   |  |  |  | MAY 27, 1984   |  |   |  | P. M.                          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR                |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR<br>JULY 14, 1896  |  | 87 YRS.   |  | MONTHS DAYS HOURS MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                |  |
| MARYLAND  |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  | MD                             |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |
| BALTIMORE   |  | 2723 CHESTERFIELD AVE  |  | SUPERVISOR   |  | RAIL ROAD   |  |                                |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE |  |
| MARYLAND  |  |  |  | BALTIMORE  |  |   |  | 21213 2723 CHESTERFIELD AVE    |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS          |  |
| FIRST MIDDLE LAST<br>THEODORE J. SCHIRMER   |  | FIRST MIDDLE LAST<br>JENNY B. HR   |  | NO   |  | 105 037536  |  | FAMILY RECORDS                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART 1: DEATH WAS CAUSED BY:<br>1850 IMMEDIATE CAUSE (a) Renal failure + Anemia<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) Carcinoma of prostate<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 mo |  |  |  |  |  |   |  |                                |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18   |  |  |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1983 to May 1984 that (I) (we) lost the deceased alive on Dec 1984 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |   |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                     |  |   |  |                                |  |
| DR. WYMAN Wong  |  | 6801 BEL AIR ROAD  |  |  |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                |  |
| BURIAL  |  | JUN 1, 1984  |  | HOLY ROSARY  |  | BALTIMORE MARYLAND  |  |                                |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |
| EVANS CHAPL OF MEMORIES   |  | 8800 RO. HARBOR  |  | JUN 4 1984   |  | John Davidson-Randall   |  |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT NOTE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ISRAEL SCHLAFFER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-3-84</b> |   | 2b. HOUR<br><b>11<sup>15</sup> AM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-20-1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HEBREW</b> |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>2918 DAMASCUS CT., APT. C (21209)</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETA WINTER (21215)</b>  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-30-527</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. ROSE SCHLAFFER 3615 FORDS LANE APT 314 (21215)</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4280 IMMEDIATE CAUSE (a) PNEUMONIA, ACUTE, BACTERIAL</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WK.</b> |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>MULTI-INFARCT DEMENTIA</b>  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-24</b> , 19 <b>79</b> , to <b>5-3</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>B. ZAN-WIN</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>5-3-84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAN-WIN, MD</b>   |  | 22e. ADDRESS<br><b>8801 LEVINDALE GERRARD CTR 21215</b>   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/4/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHERIGOVER CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTIMORE MARYLAND</b>   |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BORS, INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  |   |  | 25. DATE REG. BY REGISTRAR<br><b>MAY 8 1984</b>   |  |  |  |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED

W. T. DAVIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 20 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                                      |  |  |
|---|--|--|--|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHRISTIAN J. SCHLUTTER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 04 84</b> |   | 2b. HOUR<br><b>5:15P<sup>M</sup></b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 14 06</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4005 WILKENS AVENUE, 21229</b> |  |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>                                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONTAINER MFG.</b>  |  |  |  |   |                                      |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>---</b>   |                                      | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHRISTIAN F. SCHLUTTER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET ANNA REINHART</b>  |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-09-8034</b>   |                                      | 17. INFORMANT<br>ADDRESS<br><b>HAZEL SCHLUTTER 4005 WILKENS AVENUE, 21229</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>5860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>General Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>General Sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |                                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 4/80</u> 19 <u>81</u> to <u>05/04/84</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/30</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                                      |  |  |
| 22b. SIGNATURE<br><u>John C. Healy</u><br>DEGREE <u>MD</u>  |  |  |  | 22c. DATE SIGNED<br><u>5/7/84</u>   |                                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN C. HEALY, M.D.</b>  |  |
| 22e. ADDRESS<br><b>1311 FRANCIS AVENUE, 21227</b>   |  |  |  |   |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>05-08-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |  |  | 25a. DATE RECD. BY REGISTRAR<br><b>MAY 7 1984</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Jane Anderson-Hendall</u>   |  |

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |   |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>PAUL A. SCHMIDTCHEN SR.   |  |   |  | 2b. HOUR 8 PM   |  |   |   |
| 3. SEX MALE   |  | 4. RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 01 11   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.   |   |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>4408 ADELLE TERRACE, 21229 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY BAKERY  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 13a. STATE MARYLAND   |  | 13b. COUNTY ---   |  | 13c. CITY OR TOWN BALTIMORE   |  | 13e. STREET ADDRESS / ZIP CODE 4408 ADELLE TERRACE, 21229   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>PAUL W. SCHMIDTCHEN  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>HEDWIG UNKNOWN  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES   |  | 16b. SOCIAL SECURITY NO. WW II 218-01-6611  |  | 17. INFORMANT ADDRESS 21229 JUNE K. SCHMIDTCHEN 4408 ADELLE TERRACE   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>1629</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1629</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1629</u> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF DEATH HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>84</u> , to <u>5-13</u> , 19 <u>84</u> , that (2) (we) lost <u>1629</u> the deceased alive on <u>5-13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |
| 22b. SIGNATURE <u>Alfred Daniels</u>  |  | DEGREE <u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <u>5/14/84</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALFRED DANIELS, M.D.  |  |   |  | 22e. ADDRESS 510 E. FORT AVENUE, 21230  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT  |  | 23b. DATE 05-17-84  |  | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PK. MAUSOLEUM   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND   |   |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.  |  |   |  | 24. FUNERAL DIRECTOR ADDRESS 21229  |  | 25a. DATE REC'D BY REGISTRAR MAY 16 1984  |   |

541



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

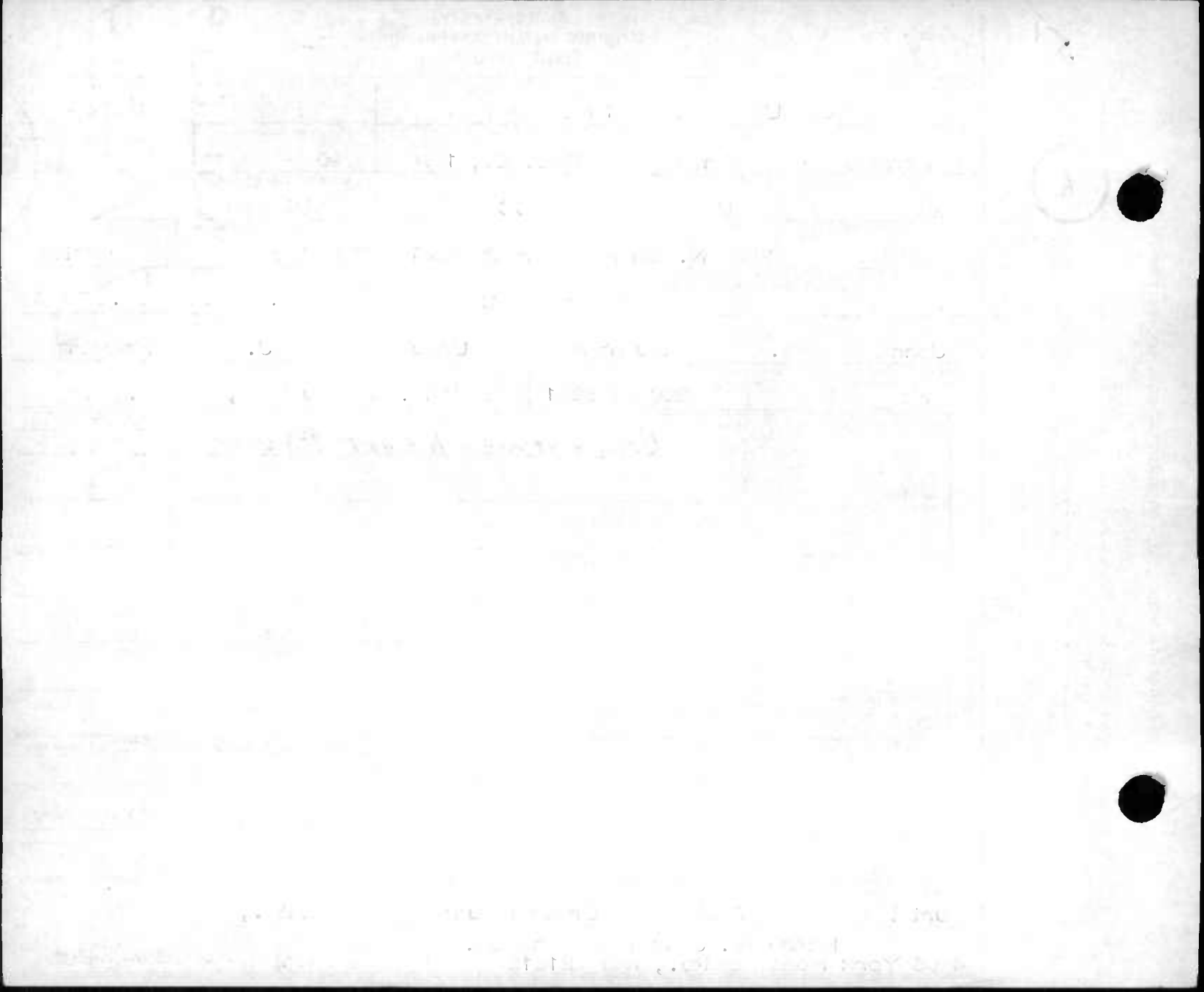
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>URSULA G. SCHMEISSER  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 25 84   |   | 2b. HOUR<br>2:10 A.M.   |   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 26, 1893  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS)<br>3900 N. Charles Street #901 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education  |
| 13a. STATE<br>MD  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John S. Slaughter   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ursula J. Hawkins   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR (UNKNOWN))<br>No  |   | 16b. SOCIAL SECURITY NO.<br>220 54 5281  |   | 17. INFORMANT<br>ADDRESS<br>Turbit H.C. Slaughter, Balto., MD                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>4280 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |  |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22. I certify that (1) this hospital attended the deceased from 5-25, 1984, that (2) we saw the deceased alive on 5-25, 1984, and that in (3) our opinion death occurred on the date and hour and from the causes stated above. (4) we (did) (did not) view the body after death. |   |  |   |   |   |
| 22b. SIGNATURE<br>Arthur M. Rinehart  |   | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>25 May 84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARTHUR M RINEHART M.D.   |   | 22e. ADDRESS<br>1900 E. NORTHERN PARKWAY   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>5/29/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |   | 23e. DATE REC'D. BY REGISTRAR<br>MAY 29 1984   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |   | 25. REGISTRAR'S SIGNATURE<br>Lisa Davidson-Randall   |   |   |   |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Schneider</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 19, 1984</b>  |  |   |  | 2b. HOUR<br>M<br><b>A</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 22, 1896</b>  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garden Village Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6129 Fairdel Ave 21206</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Dolan,</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary XHXXX Dunn</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-36-6325</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. RUTH S. Sorandes 6129 Fairdel Ave 21206</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Death</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Cardiovascular Dis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>noted</b><br><b>yes</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <b>5/16</b> , 19 <b>84</b> , to <b>5/19</b> , 19 <b>84</b> , that (if (we) lost saw the deceased alive on <b>5/16</b> (did not) view the body after death <b>5/19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James H. Keenan</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Quinlan Jr.</b> MD.   |  |   |  | 22e. ADDRESS<br><b>7801 York Road Baltimore, Maryland</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/22/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md/</b>                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 22 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

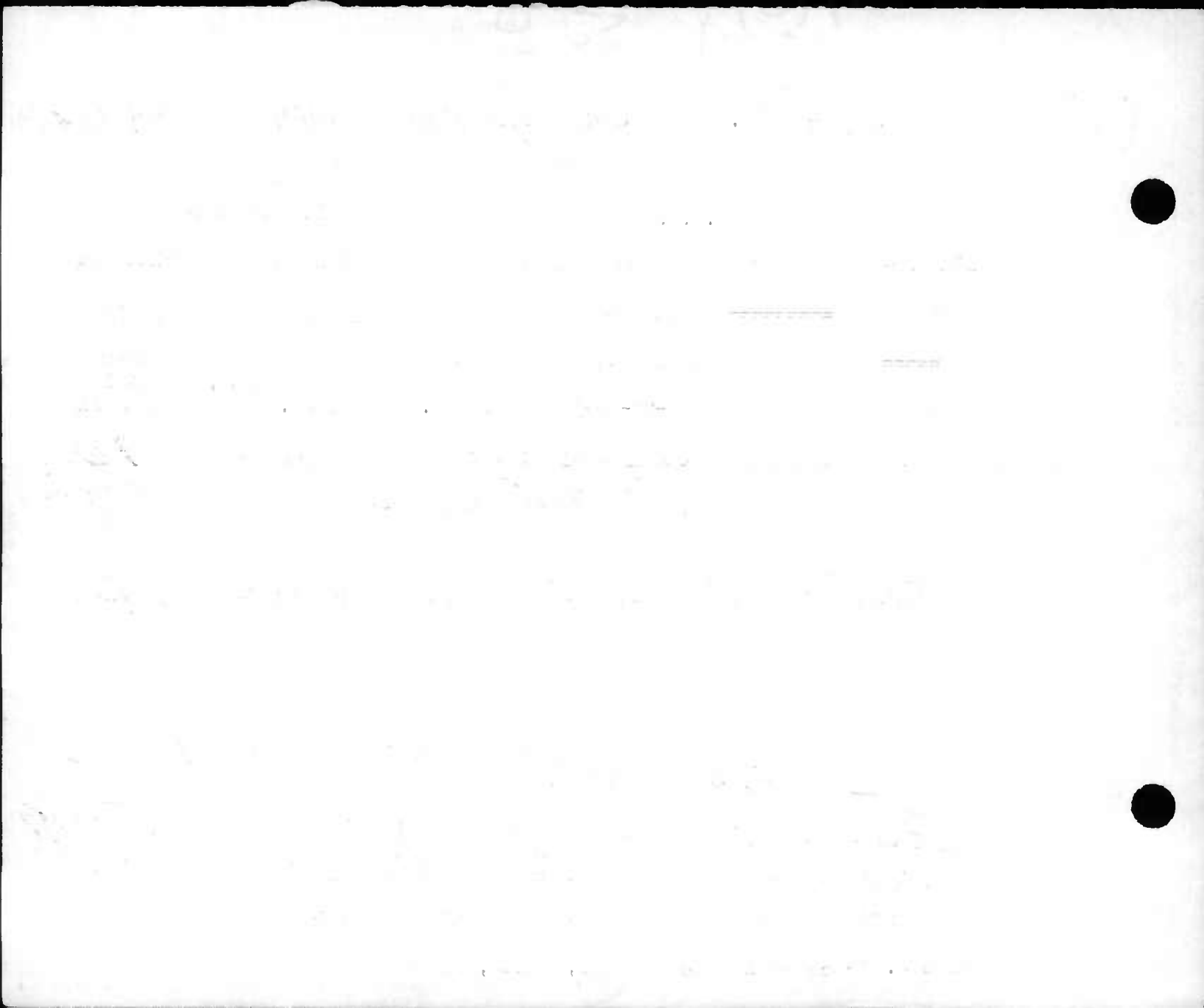
REG. NO.

|   |  |   |   |   |   |   |  |  |  |
|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA M. SCHOENWETTER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>15</b> YEAR <b>1984</b>                  |   |   | 2b. HOUR<br><b>10:45 AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>3</b> YEAR <b>04</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City</b>   |  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>=====</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>2610 Brendan Ave 21213</b>   |  |   |   |   |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>=====</b> MIDDLE <b>=====</b> LAST <b>Schoenwetter</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Emma</b> MIDDLE <b>=====</b> LAST <b>Fischer</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-4985</b>  |   | 17. INFORMANT<br>ADDRESS <b>Balto, Md 21201</b><br><b>Charles F. Rechner Jr. 1406 Fidelity Bldg</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Strangulation hernia.</b><br><b>5522</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Renal hernia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>15 yr.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr.</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>Peripheral vascular disease &amp; ASCVD</b>  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/8</b> 19 <b>84</b> to <b>5/15</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/8</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |   |   |   |  | 22c. DATE SIGNED<br><b>5/15/84</b>               |  |
| 22b. SIGNATURE<br><b>Norman R. Freeman</b>  |  |   |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN<br>MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/15/84</b>               |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NORMAN R. FREEMAN</b>   |  |   |   | ADDRESS<br><b>4300 N. Charles St - 21218</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/17/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  |   |   | ADDRESS<br><b>4001 Ritchie Hwy, Balto, Md</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # 1 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>CECILIA MARGARET SCHOLTZ   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 17, 1984   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 5, 1914  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5516 Midwood Avenue   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>5516 Midwood Road 21212  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Stubler   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cecilia Margaret Rodgers  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>219 28 2778   |  | 17. INFORMANT<br>ADDRESS<br>Charles W. Grubb, Balto., MD 21206   |  |
| MEDICAL CERTIFICATION   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF,<br>(b) <u>Malnutrition</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Chronic Hepatitis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs<br>3 months<br>2 yrs |  |   |  |   |  |  |  |
|   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerosis</u>   |  |   |  |   |  |  |  |
|   |  | 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM ETC.)<br>—  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>—  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>84</u> , to <u>May 12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Dr. William B. Rever, M.D.</u>   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>May 19, 1984</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William B. Rever, M.D.   |  | 22e. ADDRESS<br>801 Providence Rd., Balto., MD   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/21/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County, MD                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randell</u>                                     |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

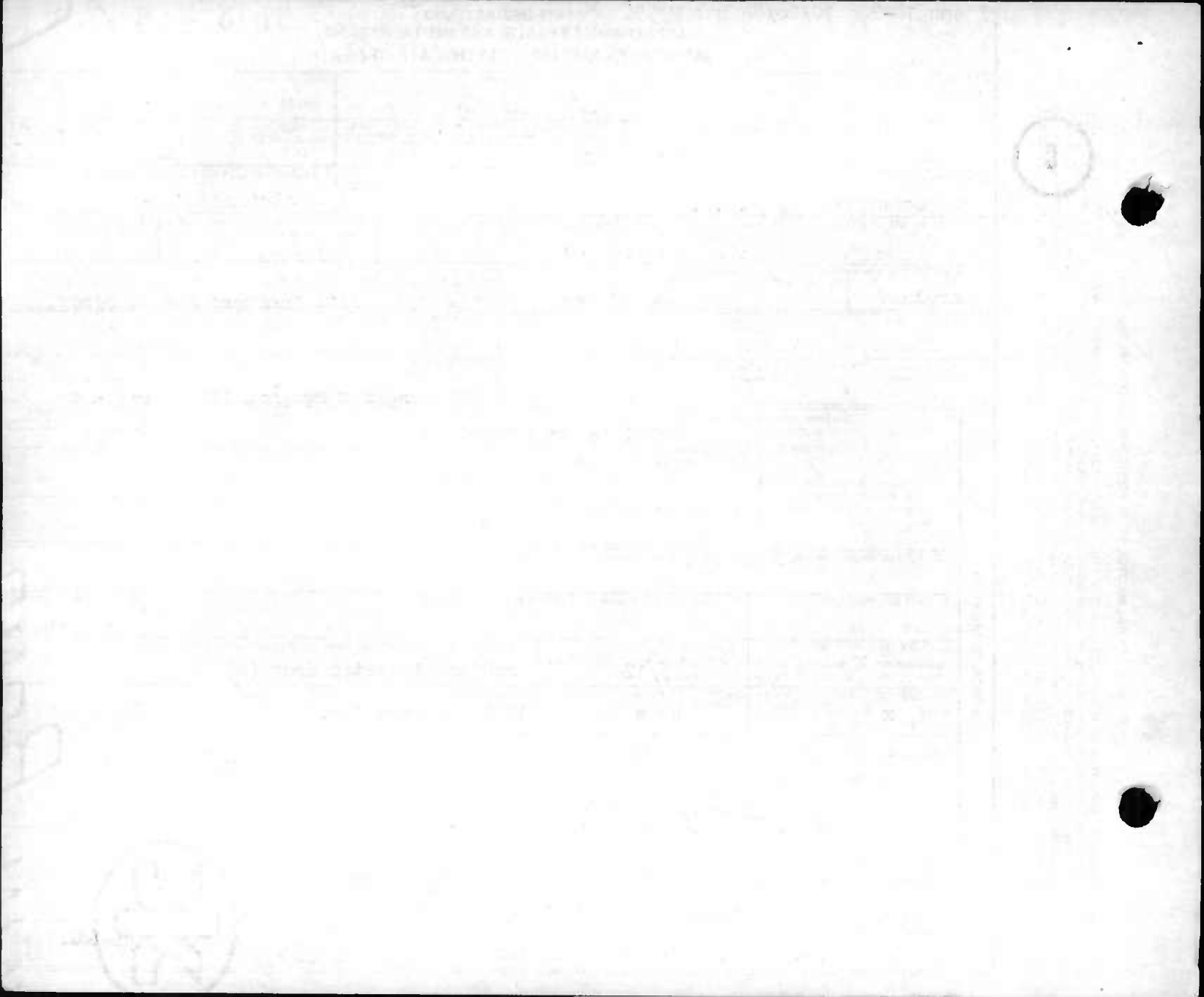
Items 18-22a 10/26/84 mtb F#596

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
|--|--|---------|-------------------|---|--|------------------------------------|--|--|----------------|---|--|---|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST |   |  | 2a. DATE KNOWN OF DEATH            |  |  | MONTH DAY YEAR |   |  | 2b. HOUR  |  |           |  |
| Susan  |  |         | Schriber          |   |  | 5/12/84                            |  |  | 19             |   |  | M   |  |           |  |
| 3. SEX   |  | 4. RACE |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.   |                | IF UNDER 24 HRS.                        |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |
| Female   |  | White   |                   | Feb 16, 1951  |  | 33 YRS.                            |  | MONTHS DAYS  |                | HOURS MIN.                              |  | 5/12/84   |  | 10:30 P M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |           |  |
| Massachusetts  |  |         |                   | U.S.A.  |  |                                    |  |  |                |   |  | Baltimore City MD.  |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |           |  |
| Baltimore  |  |         |                   | 3202 Rueckert Ave.  |  |                                    |  | Waitress   |                |   |  |   |  |           |  |
| 13a. STATE   |  |         |                   | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?   |                | 13e. STREET ADDRESS                     |  |   |  |           |  |
| Maryland   |  |         |                   |   |  | Baltimore                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                | 3202 Rueckert Ave 21214                 |  |   |  |           |  |
| 14. FATHER'S NAME  |  |         |                   |   |  | 15. MOTHER'S MAIDEN NAME           |  |  |                |   |  |   |  |           |  |
| FIRST MIDDLE LAST  |  |         |                   |   |  | FIRST MIDDLE LAST                  |  |  |                |   |  |   |  |           |  |
| Theodore Joseph Schreiber  |  |         |                   |   |  | Doris Marie Sullivan               |  |  |                |   |  |   |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |                   |   |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS  |                |   |  |   |  |           |  |
| No   |  |         |                   |   |  | 216-54-3982                        |  | Mrs Sandra M Buchman 1116 Stromko Dr Fallston, Md  |                |   |  |   |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| PART I DEATH WAS CAUSED BY: Multiple Drug Overdose   |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| IMMEDIATE CAUSE (a) _____  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF _____   |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| (b) _____  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF _____   |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| (c) _____  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| 19a. DATE OF OPERATION   |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                    |  |  |                |   |  | 20. AUTOPSY?  |  |           |  |
|  |  |         |                   |   |  |                                    |  |  |                |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |                   | 21b. TIME OF INJURY   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                |   |  |   |  |           |  |
|  |  |         |                   | HOUR A.M. MONTH DAY YEAR                                    |  |                                    |  | subject ingested drug (s)  |                |   |  |   |  |           |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                    |  | 21f. LOCATION  |                |   |  |   |  |           |  |
|  |  |         |                   | Home  |  |                                    |  | 3201 Rueckert Ave. CITY OR TOWN COUNTY STATE   |                |   |  |   |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |         |                   |   |  |                                    |  |  |                |   |  |   |  |           |  |
| ACTUAL SIGNATURE   |  |         |                   | TITLE (SPECIFY)   |  |                                    |  | DATE SIGNED  |                |   |  |   |  |           |  |
| [Signature]  |  |         |                   | M.D. Assistant MEDICAL EXAMINER                             |  |                                    |  | 5/13/84  |                |   |  |   |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |                   | ADDRESS   |  |                                    |  |  |                |   |  |   |  |           |  |
| Gregory R. Kauffman, M.D.  |  |         |                   | 111 Penn St., Balto., Md. 21201                             |  |                                    |  |  |                |   |  |   |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |                   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |                | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |   |  |           |  |
| Burial   |  |         |                   | 5/15/84   |  | Moreland Park                      |  |  |                | Baltimore, Maryland                     |  |   |  |           |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |                   | ADDRESS   |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR  |                |   |  | 25b. REGISTRAR'S SIGNATURE  |  |           |  |
| Leonard J Ruck Inc.  |  |         |                   | Baltimore, Maryland   |  |                                    |  | MAY 14 1984  |                |   |  | Julia Davidson-Randall  |  |           |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE G.H. SCHROEDER</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-13-84</b> |  |  | 2b. HOUR<br><b>4:13 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 26 98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>                                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Men's Shirt Manuf.</b>   |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>2017 Deering Avenue 21230</b>   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Hildebrand</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Kreiner</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-5580</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Doris E. Denis 2017 Deering Ave. 21230</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Overwhelming Sepsis</b><br>5741<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic cholecystitis AND cholelithiasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |  |  |  |  |  |  |
| <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>5-13-84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 1981</b> to <b>PRESENT</b> 19____, that (I) (we) last saw the deceased alive on <b>MAY 13 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. N. M. Machiran</b>  |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-13-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. N. M. MACHIRAN</b>   |  |  |  | 22e. ADDRESS<br><b>4713 LEEDS AVE., ARBLUTHS, MD, 21227</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/16/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1984</b>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | REG. NO.   |   |
|--|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WINIFRED SCHUMAN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>10</b> YEAR <b>84</b>                                |  | 2b. HOUR<br><b>2:30</b> M                           |
| 3. SEX<br><b>F</b> FEMALE  | 4. RACE<br><b>C</b> CAUCASION  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>2</b> YEAR <b>1910</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp of Balto.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NURSING</b> |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3814 Dorchester Rd. 21215</b>                              |   |
| 14. FATHER'S NAME<br>FIRST <b>SAMUEL</b> MIDDLE <b>E.</b> LAST <b>LEVIN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>JENNIE</b> MIDDLE <b>G.</b> LAST <b>BRAGER</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-6934</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. PEARL YARMACK 3814 DORCHESTER RD. 21215</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probs. Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b><br>Approximate interval between onset and death: <b>60 min</b> |  |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-10-84</b> to <b>5-10-84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-10-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                       |  |  |   |  |   |
| 22b. SIGNATURE<br><b>Steven L. Joffe M.D.</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>5-10-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven L. Joffe M.D.</b>   |  | 22e. ADDRESS<br><b>Sinai Hosp of Balto.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/11/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>AITZ CHAIM CEM</b>                          |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>BALTIMORE</b>  |  | COUNTY<br><b>MARYLAND</b>  |   | STATE  |   |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>MAY 15 1984</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>Jana Barabara</b>                                    |   |
| 6010 REISTERSTOWN BALTIMORE, MARYLAND 21215  |  |  |   |  |   |

RECEIVED  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.



BALTIMORE

U.S. DEPARTMENT OF THE ARMY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

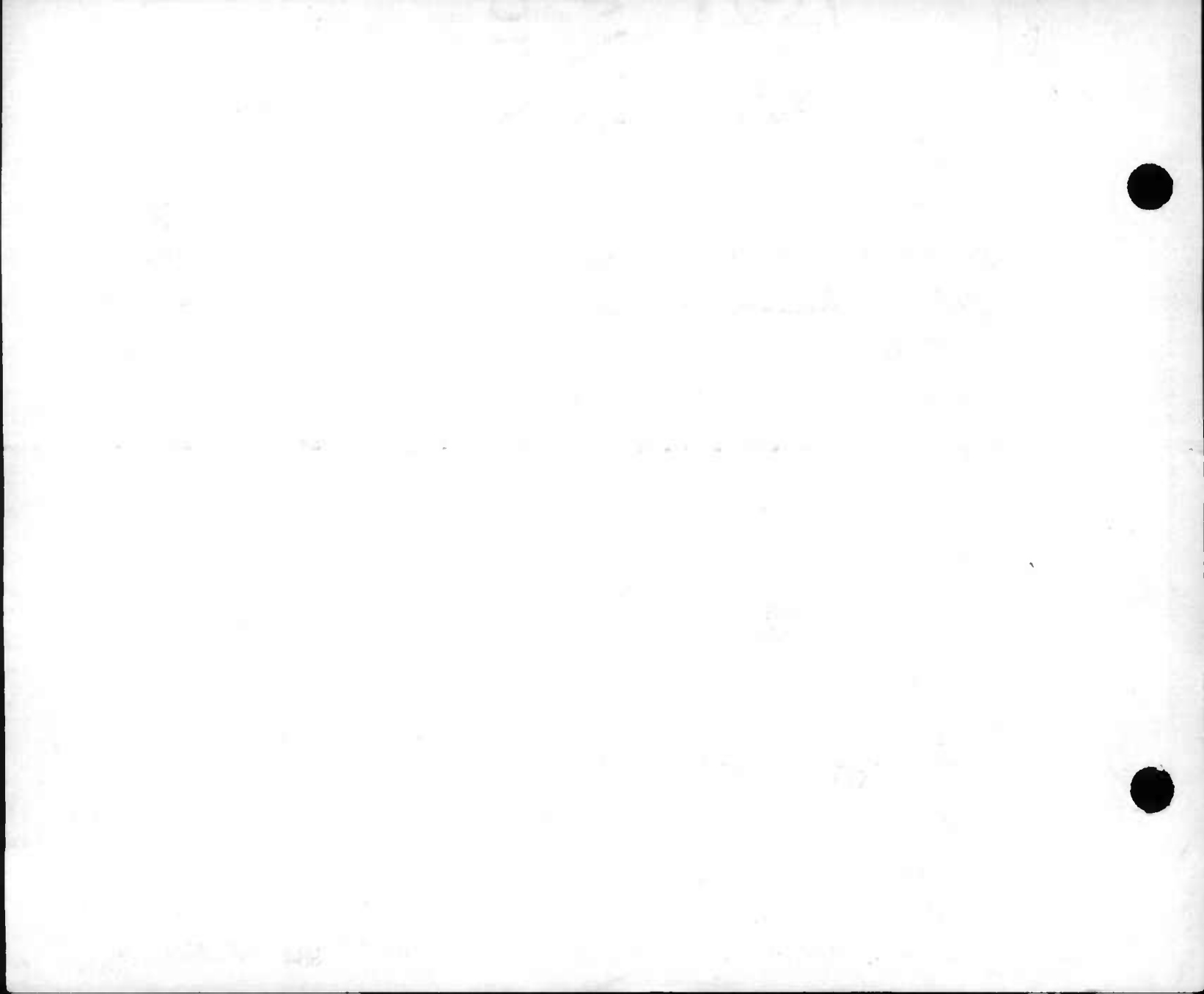
REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Victor Seader</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 / 9 / 84</b>                            |   | 2b. HOUR<br><b>9:21 AM</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>Cauc</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 20 10</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Car Company</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD.</b>  |  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Seader</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Losey Norton</b>                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unk.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>055-07-8580</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Medical Record</b>                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/30</b> 19 <b>84</b> , to <b>5/9</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Paul S. Herman</b> M.D.  |  |   |   | 22c. DATE SIGNED<br><b>5/9/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul S. Herman</b>  |  |   |   | 22e. ADDRESS<br><b>3001 S. Hanover</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 10, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>              |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |  | COUNTY<br><b>AA</b>   |   | STATE<br><b>MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James S. Kirkley, Glen Burnie, MD</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1984</b>                           |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

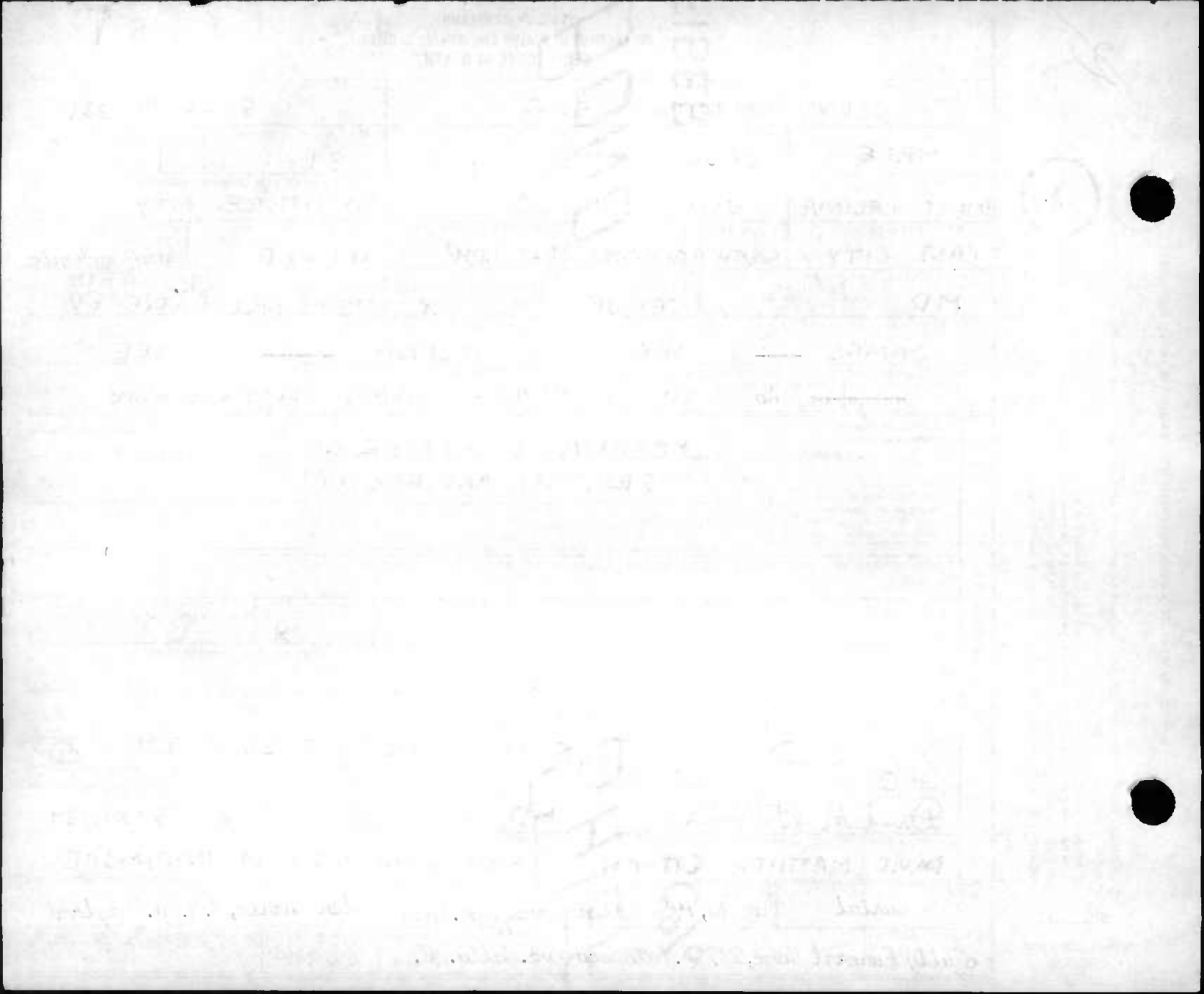
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GLENN RANDOLPH SEE</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 26 84</b>                              |   | 2b. HOUR<br><b>2315</b> M   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUC</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 23 02</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>81</b>                                 | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTI. CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN. HOSP</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Mechanic</b>   |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. CITY OR TOWN<br><b>JESSUP</b>  | 13c. STREET ADDRESS / ZIP CODE<br><b>7873 BROCKBRIDGE RD</b>                      |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JAMES SEE</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SELENA SEE</b>                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 09 0280</b>  |   | 17. INFORMANT ADDRESS<br><b>WIFE SAME ADDRESS as above</b>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1850 METASTATIC CANCER OF PROSTATE AND RECTUM</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5 16</b> , 19 <b>84</b> , to <b>5 26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.               |  |   |   |   |   |
| 22b. SIGNATURE<br><b>David M Witham</b>   |  |   |   | 22c. DATE SIGNED<br><b>5/26/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID MATTHEW WITHAM</b>  |  |   |   | 22e. ADDRESS<br><b>3001 S. HANOVER ST BALTIMORE</b>                               |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 30, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                 |   |
| 24. FUNERAL DIRECTOR<br><b>McCutty Funeral Home, 237 E. Patapsco Ave. Balto.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. ...</b>                                    |   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co. Maryland</b>  |  |   |   |   |   |

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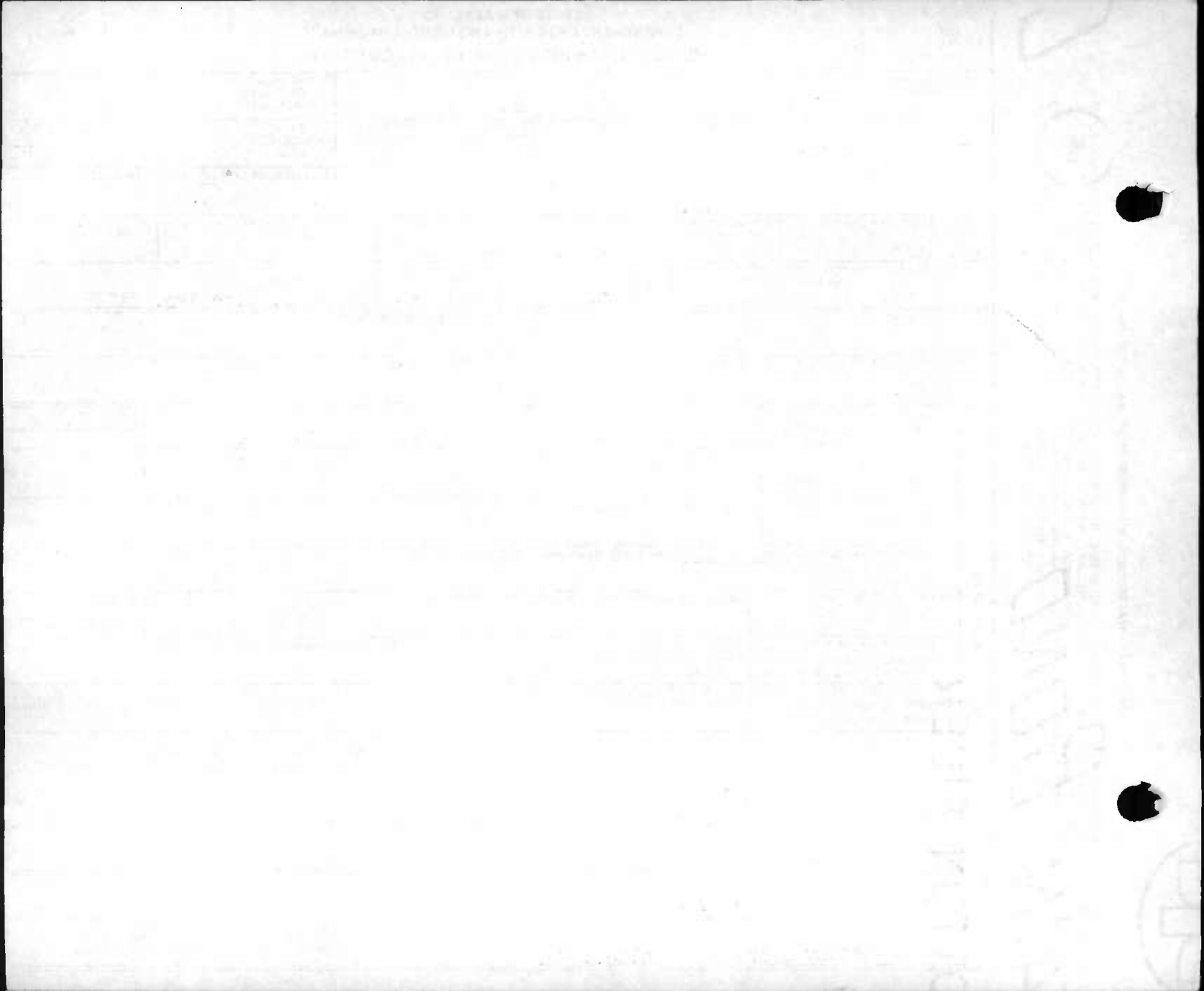
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Doris Seelcher</u>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 5/12/84 |  |
| 3. SEX <u>Female</u> 4. RACE <u>White</u> 5. DATE OF BIRTH MONTH DAY YEAR <u>70</u> 6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS. 7. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u>   |  |  |  |  |  |  |  |  |  | 2b. HOUR <u>6:03</u> AM  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore Gen. Hosp.</u> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <u>Md.</u> 13b. COUNTY <u>Balto.</u> 13c. CITY OR TOWN <u>Balto.</u> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>202 E. 11th Ave. 21225</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Unkn.</u> 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><u>4292</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Gregory R. Kauffman, M.D.</u> TITLE (SPECIFY) <u>Assistant</u> MEDICAL EXAMINER DATE SIGNED <u>5/13/84</u>  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Gregory R. Kauffman, M.D.</u> ADDRESS <u>111 Penn St., Balto., Md. 21201</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u> 23b. DATE <u>5/22/84</u> 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Anatomy Board</u> ADDRESS <u>Balto., Md.</u> 25a. DATE REC'D. BY REGISTRAR <u>MAY 29 1984</u> 25b. REGISTRAR'S SIGNATURE <u>Jehia Davidson-Randell</u>   |  |  |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION





**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |   |  |
|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Evelyn Ruth Seifert</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 22 84</i> |   |  | 2b. HOUR<br><i>5:20 A.M.</i>  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Apr. 8, 1903</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i>                                  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Cole</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Eva Belle Thomas</i>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>  |  |   |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>213-48-4642</i>   |  | 17. INFORMANT ADDRESS<br><i>Ruth C. Wade, 6006 Glennor Rd. 21239</i>  |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>4140</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>anaphylaxis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>atherosclerosis coronary artery disease</i>                             |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>MAY 5, 1984</i> , to <i>MAY 22, 1984</i> , that (I) (we) last<br>saw the deceased alive on <i>MAY 22, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><i>B. Brandon</i>  |  | 22c. DEGREE<br><i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  |   | 22d. DATE SIGNED<br><i>5/22/84</i>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>B. Brandon MD</i>  |  | 22f. ADDRESS<br><i>Mary, Hospital, St Paul St Balto Md 21202</i>  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>May 25, 1984</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olivet</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i>                              |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br/>6009 Harford Rd., Balto., Md. 21214</i>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 23 1984</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 5 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |  |   |   |   |                            |  |
|--|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Jonathan Selvage</u>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>5/22/84</u>  |   |   | 2b. HOUR<br><u>7:25 AM</u> |  |
| 3 SEX<br><u>M</u>  | 4 RACE<br><u>White</u>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><u>3 30 84</u>  | 6 AGE (IN YEARS, LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><u>1 22</u>                              |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><u>1 22</u>           |                            | IF UNDER 24 HRS<br>HOURS MIN.<br><u>7 25</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>USA</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>City</u>  |   |   |                            | MD.  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore City</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>114 Washington Pediatric Hospital</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY                       |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Baltimore</u> 13b. COUNTY <u>old</u> 13c. CITY OR TOWN <u>Baltimore City</u> |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><u>7842 1/2 Belair Rd. 21236</u> |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Daryl D. Selvage</u>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Patricia Selvage Kidd</u>  |   |   |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><u>none</u>  |   | 17. INFORMANT<br>ADDRESS<br><u>Daryl D. Selvage 7842 1/2 Belair Rd. 21236</u> |   |                            |  |

|  |  |  |
|--|--|--|
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest Hypovolemia</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2d</u> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypovolemia Cerebral Rupture of the brain</u>   |  | <u>2d</u>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Leaking hydrocephalus</u>   |  | <u>~ 9 mon (prenatal)</u>                                    |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
Occipital and Cervical Encephalococles

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION<br><u>None</u>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <u>84</u>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                         |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>1305 Park Avenue Balto Baltimore, Maryland</u> |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>84</u> to <u>5/22</u> 19 <u>84</u> , that (I) (we) last<br>saw the deceased alive on <u>5/22</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>John Santelli</u>  | DEGREE<br><u>MD</u>  | 22c. DATE SIGNED<br><u>5/22/84</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John Santelli</u>   | 22e. ADDRESS<br><u>1305 Park Avenue Balto 21217</u>                    |  |   |

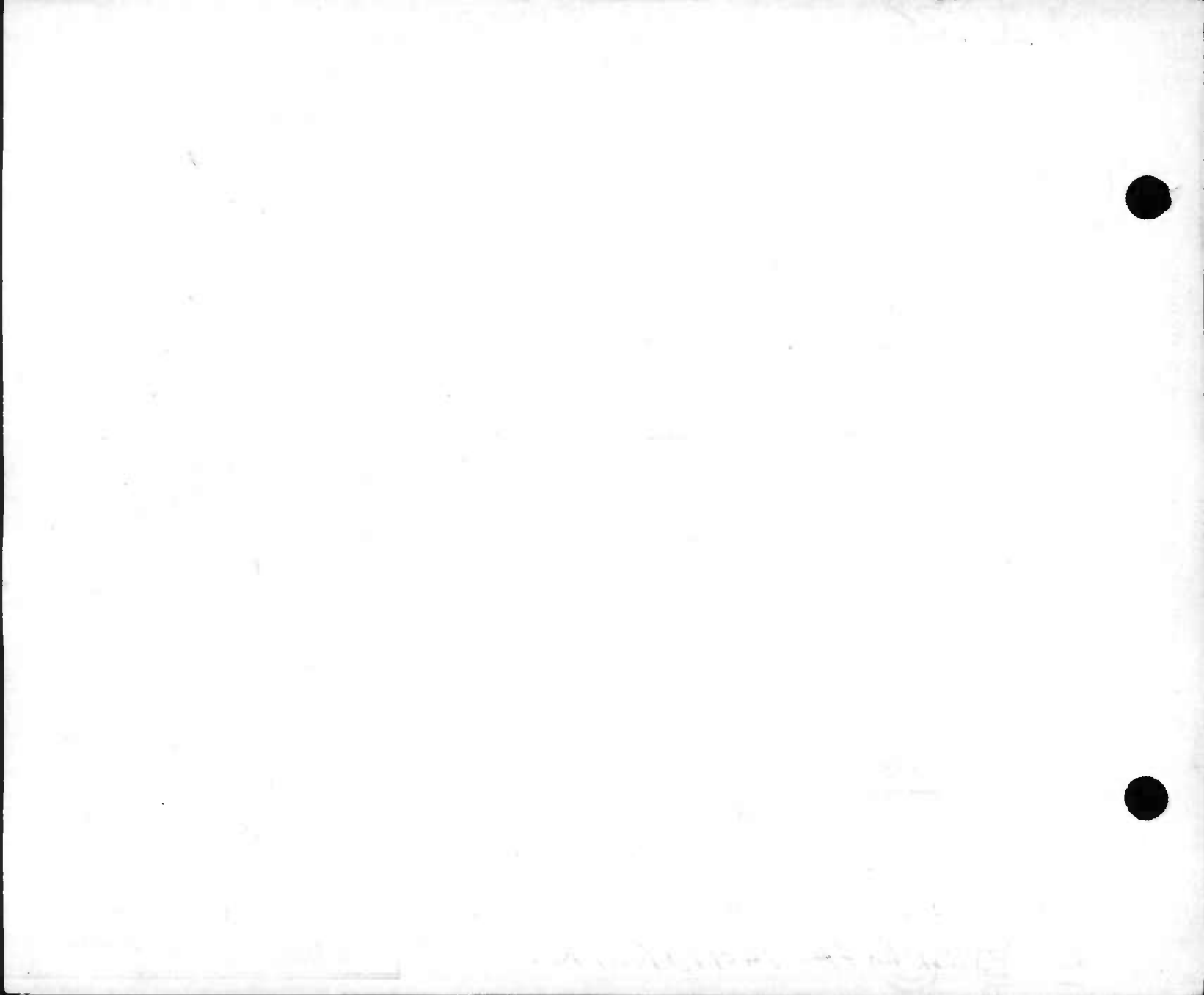
|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>5-24-84</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gardens of Faith</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>Assesson H. 7401 Belair Rd 21234</u> |                             | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 28 1984</u>           | 25b. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Randall</u>               |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in block 18.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

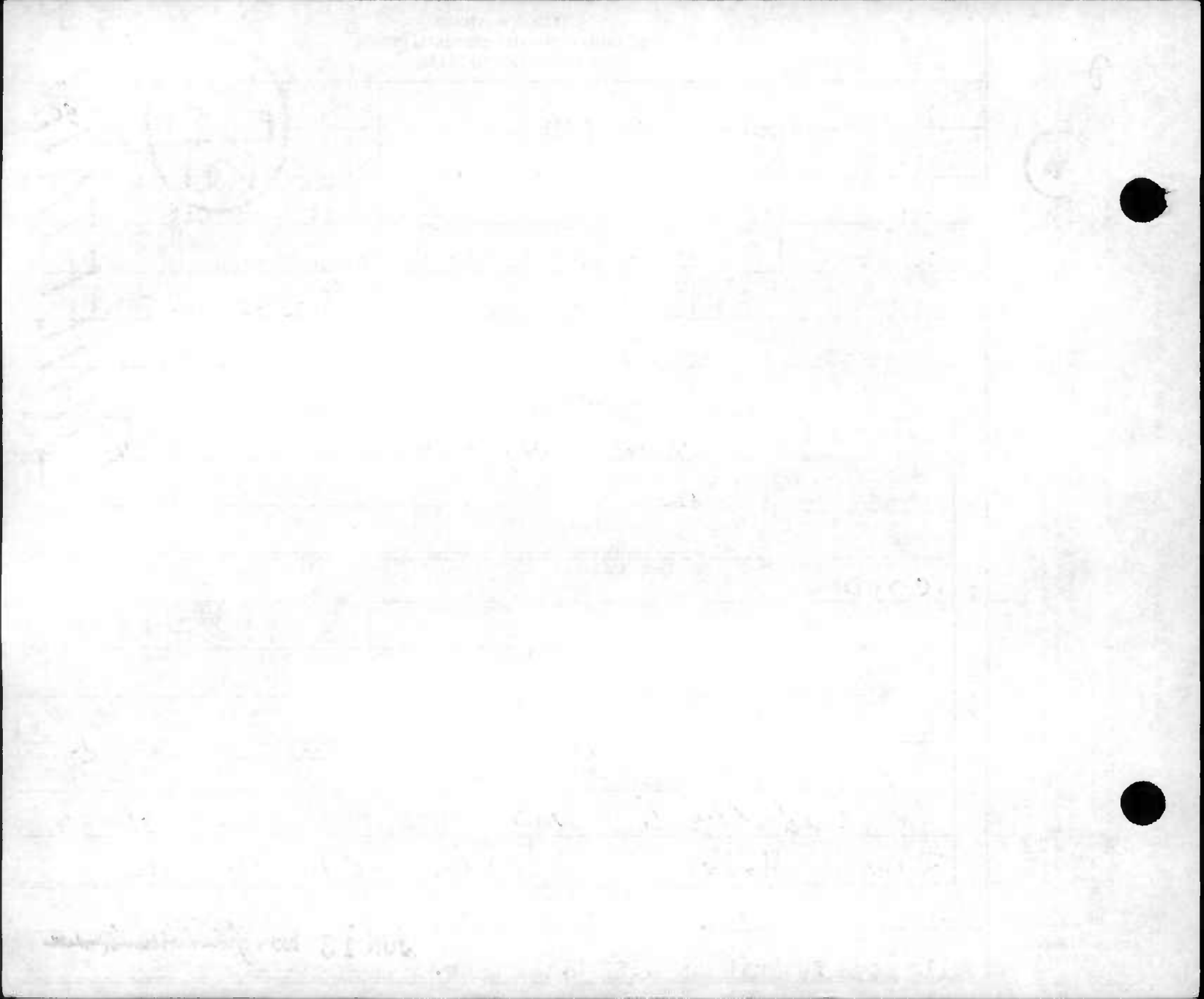
REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Pietro Serafini</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 12 84</b>                                  |   | 2b. HOUR<br><b>0090 AM</b>                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 21, 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Stone Mason</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Serafini</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Pepi</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-9564A</b>   |  | 17. INFORMANT ADDRESS   |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 MIN</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PEP</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |

|   |  |   |  |
|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>COPD</b>  |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> , 19 <b>84</b> , to <b>5/13</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Richard Hodes</b> MD   |  | 22c. DATE SIGNED<br><b>6/8/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD HODES</b>   |  | 22e. ADDRESS<br><b>Baltimore City Hospital</b>                                |  |

|   |                              |   |   |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Buried</b>                              | 23b. DATE<br><b>5/14./84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Maus.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Della Noce Funeral Home, 322 S. High St.</b> |                              | 25. FILED<br><b>JUN 13 1984</b>                                   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 5 6

|  |  |  |  |
|--|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN F. SESSOMS</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>5-4-84</b>   |  |
| 3. SEX <b>F</b>  |  | 2b. HOUR <b>12 MM</b>  |  |
| 4. RACE <b>B</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>68</b>  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR <b>09 12 15</b>  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hosp</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>   |  |
| 13a. STATE <b>MD.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  |
| 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 13e. STREET ADDRESS / ZIP CODE <b>700 Ross Ave SE 21225</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES SOLLA</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MARTIN</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>212-34-7956</b>  |  |
| 17. INFORMANT ADDRESS <b>Banana Island</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac / respiratory arrest</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>complication of the lung infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastases</b>                                       |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immed</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>NIDDM, ASCVD, hx CVA</b>  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> , 19 <b>84</b> , to <b>5/5</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE <b>Bruce Bumenthan MD</b> DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>5/5/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce Bumenthan MD</b>  |  | 22e. ADDRESS <b>900 Washington Blvd Baltimore, MD 21230</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>   |  | 23b. DATE <b>5/10/84</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Wesleyview</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City MD 21225</b>   |  |
| 24. FUNERAL DIRECTOR <b>John D. Dwyer 438 N 9th Mon St</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1984</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>John D. Dwyer</b>  |  |  |  |





8 4 1 3 3 5 7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY C. SHAGOGUE</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 7 84</b>   |  | 2b. HOUR<br><b>11:25<sup>M</sup></b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 3 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                               | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Infant Nurse</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS<br><b>4247 Drayton Green 21227</b>                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George M. Elder</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rosalind Austin</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-28-8221</b>  |   | 17. INFORMANT ADDRESS<br><b>David Deal 519 King Malcom Ave. 21113</b>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140 IMMEDIATE CAUSE (a) Cardio respiratory arrest</b>   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>multiple pulmonary emboli</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery dis and atheria pneumonia, COLD</b>  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>H. TAVASSOLIE</b>  |  |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. TAVASSOLIE MD</b>  |  |   |   | 22e. ADDRESS<br><b>3455 WILKIENS AVE, BALT, MD 21229</b>                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/11/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>10 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-20000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 5 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

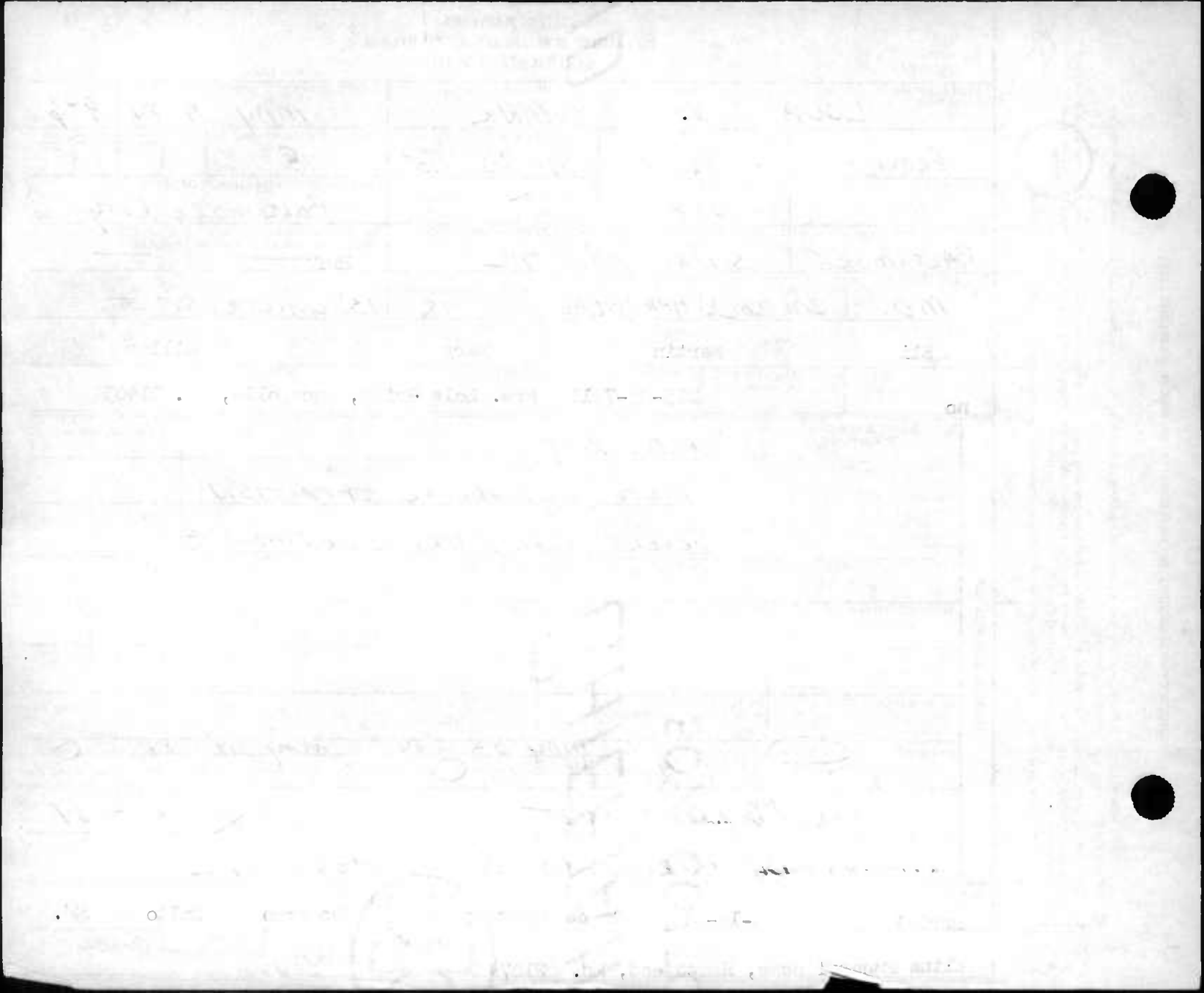
|   |  |  |   |   |                             |  |  |
|---|--|--|---|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOLA A. SHANK</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 09 84</b> |   | 2b. HOUR<br><b>940 P.M.</b> |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 20 05</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>78</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hwt</b>  |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>CARROLL</b>  |   | 13c. CITY OR TOWN<br><b>HAMPSTEAD</b>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eli Martin</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Miller</b>  |   | 16. STREET ADDRESS<br><b>1322 HILCREST ST.</b>  |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-7311</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Lola Grimm, Annapolis, Md. 21403</b>  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESP</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>SEVERE COPD / ATRIAL ARRHYTHMIAS</b> |  |  |   |   |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |   |                             |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 03 19 84</b> to <b>MAY 09 19 84</b> , that (I) (we) last saw the deceased alive on <b>MAY 09 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |                             |  |  |
| 22b. SIGNATURE<br><b>Robert DeMarco, MD</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                             | 22c. DATE SIGNED<br><b>5-9-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT DE MARCO MD</b>  |  |  |   | 22e. ADDRESS<br><b>Sinai Hosp. Md.</b>  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-12-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grace Cemetery</b>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upperco Balto Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home, Hampstead, Md. 21074</b>   |  |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1984</b>  |                             | 26. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 5 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Jerome Sheard</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>5 30 84</i>  |  |   |  | 2b. HOUR<br><i>925 A M</i>  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 25 34</i>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><i>49</i> YRS.                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S. Carolina</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY, MD.</i>        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>J.L. DEATON MEDICAL CENTER</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><i>Maryland</i>   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 13e. STREET ADDRESS / ZIP CODE<br><i>2814 E. Monument St. 21205</i>   |  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>- - -</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Eva Alston</i>        |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>248-46-8528</i>   |  | 17. INFORMANT ADDRESS<br><i>Shelby J. Arnold 2814 E. Monument St.</i>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>3481</i> IMMEDIATE CAUSE (a) <i>anoxic Encephalopathy</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Extensive Bedsores and</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Possible Sepsis</i>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-3</i> , 19 <i>84</i> , to <i>5-30</i> , 19 <i>84</i> , that (I) (we) last<br>saw the deceased alive on <i>5-30</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  |  | 22c. DATE SIGNED<br><i>5/30/84</i>  |  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D.S. SAWHNEY</i>  |  |
| 22e. ADDRESS<br><i>7422 B+A Blvd Glen Burnie</i>  |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>  |  | 23b. DATE<br><i>6/4/84</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Zion Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Lansdowne, Md.</i>       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm C March F/H Inc, 1101 E North Avenue</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 1 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                          |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

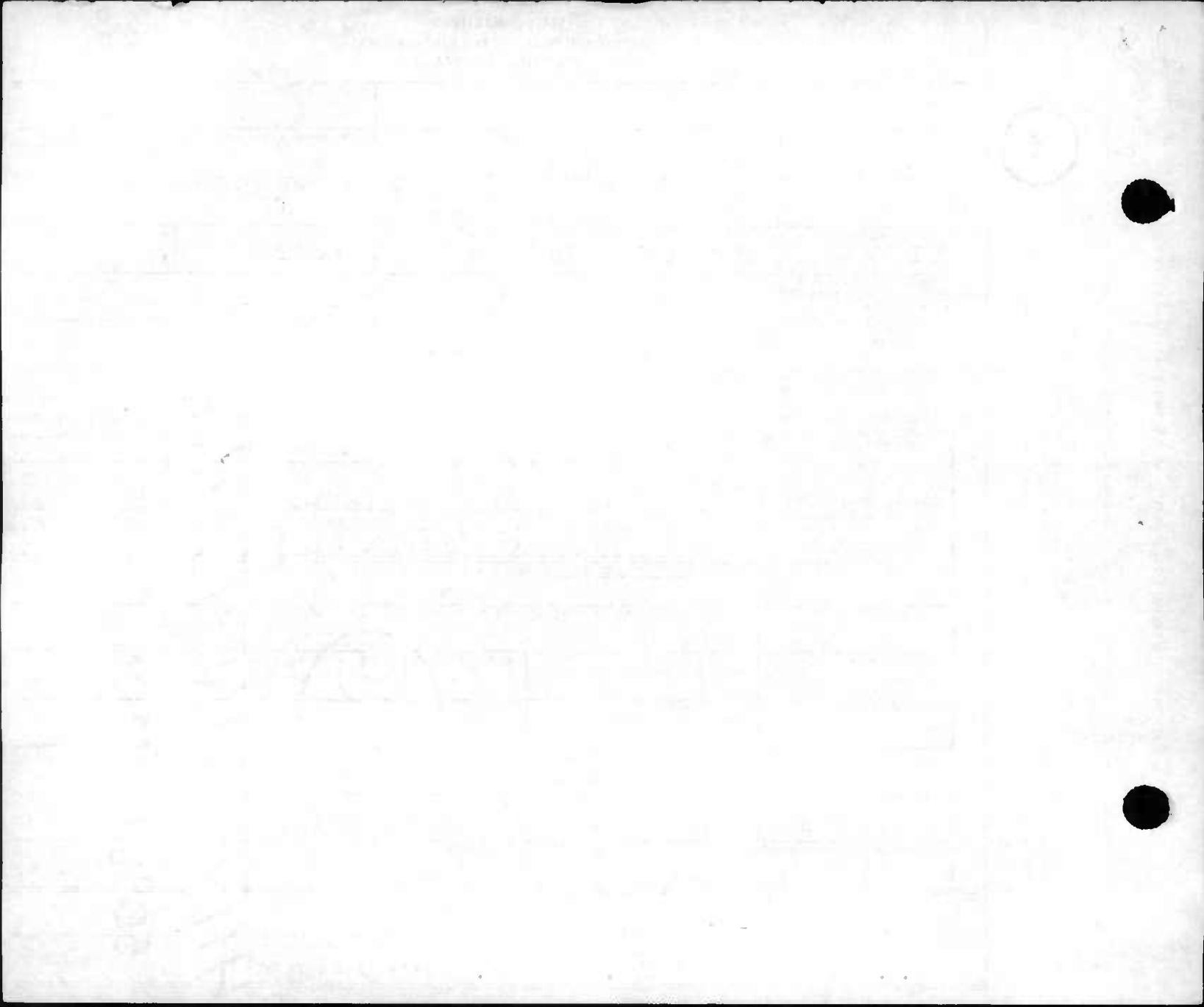
BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RALPH SHEARD</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 24 84</b> |   |  | 2b. HOUR<br>M<br><b></b>   |  |
| 3 SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 23 22</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>FLORDIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br><b>611 GEORGE STREET</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MAIN SOURCE OF WORKING LIFE)<br><b>DISABLED</b>                                  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTHONY SHEARD</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GEORGIA HILL</b>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |   | 17 INFORMANT<br>ADDRESS<br><b>ISADORE SHEARD 2829 PRESSTMAN ST.</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cancer of the larynx.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Seizure Disorder</b> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec - 19 77</b> to <b>2-17 19 84</b> , that (I) (we) lost saw the deceased alive on <b>2-17-19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Aurzano</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5-25-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aldo Paz</b>   |  |  |   | 22e. ADDRESS<br><b>1000 Eager St Balto - Md 21202</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-26-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FLORDIA</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS</b>  |  |  |   | ADDRESS<br><b>1721 N. MONROE ST.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLEN M. SHEELER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/6/84</b> |   |  | 2b. HOUR<br><b>6:03 A.M.</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 9 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Convalesarium</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory Worker</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electronics</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Schroeder</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Loretta White</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3406 Ramona Ave., 21213</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT ADDRESS<br><b>Edna M. Shipley, 3406 Ramona Ave., 21213</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OF BRAIN FROM BREAST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA OF BREAST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>METASTATIC CARCINOMA OF LUNG.</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (i) this hospital attended the deceased from _____, 19____, to _____, 19____, that (i) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did not) see the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>5/7/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luis E. Rivera, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Belair Convalesarium, Balto, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/9/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, Md.</b>                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SCHIMUNEK FUNERAL HOME, 3331 Brehms La, 21213</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

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2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 6 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |   |  |  |
|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANTONIA SHELL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/5/84</b>                   |   |  | 2b. HOUR<br><b>5:45 P.M.</b>  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 5 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.                         |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Hosp</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>3323 Dolfield Ave. 21215</b>  |  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Edmonds</b>        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Mason</b>      |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>ADDRESS<br><b>Mattie Christopher 3323 Dolfield Ave.</b>       |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4280 Cardiac Arrest</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> , 19 <b>84</b> , to <b>5/5</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>W. Royal, M.D.</b>  |  |   |  |   | DEGREE   |   | 22c. DATE SIGNED<br><b>5/5/84</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. ROYAL, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>2600 Liberty Heights</b>                                    |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5/10/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union Church Cem.</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Meredithville, Va.</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. March F/H,</b>  |  |   |  |   | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>   |  |  |
|  |  |   |  |   | 26. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                     |   |   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_  
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MAY 2 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and page 4 must be retained by the medical examiner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO. 84-13363   |  |   |  |  |
| 1. DECEASED NAME<br>[TYPE OR PRINT] <b>Dolores May Sheppard</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 5 84</b>  |  | 2b. HOUR<br><b>4:50 P M</b>   |  |  |
| 1. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 2 1934</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>49</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Credit Counselor-Dept.Store</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7615 Charlesmont Rd. 21222</b>     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stephen A. Martin</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen M. Colly</b>                          |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-32-6489</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>W. Richard Sheppard, II Same as 13e</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung with</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic spread to Brain</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8:11 3/77 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3427 Dundalk ave Baltimore Maryland</b> |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Apr. 23, 1984</b> to <b>April 25, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>Apr. 23, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) show the body after death.                                      |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Theo. C. Patterson MD</b>   |  |   |  |   | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>5/7/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THEO. C. PATTERSON</b>   |  |   |  |   | 22e. ADDRESS<br><b>3427 Dundalk ave 21222</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5/9/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>                |  |  |

Page 1

1. The first part of the report is a general description of the area. It is a small, flat, open area with a few scattered trees and a small stream. The soil is sandy and the vegetation is sparse. The area is located in the north-east corner of the plot.

2. The second part of the report is a detailed description of the vegetation. It is a mix of grasses, sedges, and small shrubs. The grasses are mostly tall and thin, with some shorter, wider leaves. The sedges are small and have long, narrow leaves. The shrubs are small and have rounded leaves. The vegetation is mostly green, but some of the grasses are turning brown.

3. The third part of the report is a description of the soil. It is a sandy soil with a high water table. The soil is mostly light brown, but there are some darker patches. The soil is very loose and crumbly. The water table is about 1 meter below the surface.

4. The fourth part of the report is a description of the stream. It is a small, shallow stream with a sandy bed. The water is clear and flows slowly. The stream is about 10 meters long and is located in the south-west corner of the plot.

5. The fifth part of the report is a description of the birds. There are several birds in the area, including sparrows, finches, and a few larger birds. The birds are mostly seen in the trees and the stream. They are mostly active during the day.

6. The sixth part of the report is a description of the insects. There are many insects in the area, including beetles, flies, and bees. The insects are mostly seen on the ground and the vegetation. They are mostly active during the day.

7. The seventh part of the report is a description of the plants. There are many plants in the area, including grasses, sedges, and small shrubs. The plants are mostly green, but some of the grasses are turning brown. The plants are mostly located in the north-east corner of the plot.

8. The eighth part of the report is a description of the animals. There are many animals in the area, including birds, insects, and small mammals. The animals are mostly seen in the trees and the stream. They are mostly active during the day.

9. The ninth part of the report is a description of the weather. The weather is mostly clear and sunny. There are a few clouds in the sky. The temperature is about 20 degrees Celsius. The wind is light and comes from the north.

10. The tenth part of the report is a description of the overall environment. It is a small, flat, open area with a few scattered trees and a small stream. The soil is sandy and the vegetation is sparse. The area is located in the north-east corner of the plot.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |   |   |   |  |
|---|--|--|--|---|---|---|---|---|--|
| 1- EOR<br>STATE<br>REGISTRAR PAULINE VIRGINIA SHIELDS CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAULINE Virginia SHIELDS</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>3</b> YEAR <b>84</b> 2b. HOUR <b>3:30PM</b>          |   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>2</b> YEAR <b>15</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                           |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Credit Dept.</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>=====</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2643 Wilkens Avenue 21223</b>                          |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Mont</b> MIDDLE <b>Greene</b> LAST <b>Greene</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ada</b> MIDDLE <b>Jackson</b> LAST <b>Jackson</b>          |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>232-46-0435</b>   |  | 17. INFORMANT<br><b>Douglas D. Shields</b> ADDRESS<br><b>Same as 13e</b>  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>5839</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic sclerosing glomerulonephritis</b>   |  |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>Granulomatous pneumonitis - cavitation 2° to M. intracellulare</b>  |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |   | COUNTY  | STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>84</b> , to <b>5/3</b> , 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>5/3</b> , 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. |  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>William J. Hicken</b> MD   |  |  |  |   | DEGREE <b>MD</b>  |   |   | 22c. DATE SIGNED<br><b>5/4/84</b>                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W J HICKEN MD</b>   |  |  |  |   | 22e. ADDRESS<br><b>St Agnes Hospital</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>5/7/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Roselawn Mem Gardens</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Princeton</b> COUNTY <b>West Va.</b> STATE <b>West Va.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b> 4001 Ritchie Hwy Balto Md  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 7 1984</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |   |   |  |

3



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 6 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE M. SHIFFMAN</b>                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05/28/84</b>                               |   | 2b. HOUR<br><b>2:35P.M.</b>                         |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 6 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b><br>YRS. MONTHS DAYS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b> |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Timothy Ryan</b>              |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nana Sylvia Reeder</b>           |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-01-6026A</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Harry Shiffman same as # 13</b>   |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1749</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>PANCYTOPENIA</b><br>(c) <b>METASTATIC BREAST CA</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/14</b> 19 <b>84</b> , to <b>5/28</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/28</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Elena Barraquer</b>   | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5/28/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elena Barraquer</b>  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>  |  |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                | 23b. DATE<br><b>6/1/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>                |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24-hour death file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use at the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 5 6 6

1 - FOR  
STATE  
REGISTRAR

REG. NO:

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MADONNA B. SHILLER</b><br><i>Madonna B. Shiller</i>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 18 84</b>   |  | 2b. HOUR<br><b>1:00 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 6 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ILLINOIS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ of Md.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ASSEMBLER and</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Ellicott City</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3814 Plum Meadow Dr. 21043</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRISON - GOBLE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LILLIAN M. FOSTER</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-2349</b>  |  | 17. INFORMANT<br><b>CARROLL SHILLER</b> ADDRESS <b>ELLICOTT CITY, MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1989 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Bladder Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>3 1/2 years</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Leukopenia &amp; Thrombocytopenia</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)<br><b>N/A</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> , 19 <b>84</b> , to <b>5/18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Duane I Smoot MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/18/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Duane Smoot MD</b>   |  |   |  | 22e. ADDRESS<br><b>22 S Green St Balto Md 21201</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>05-21-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1984</b>  |  |  |  |

BP

*John Davidson*

McLennan E. Shiller

Frank  
W. H.  
Baltimore  
H. H.  
H. H.

Confidential Agent  
Metropolitan Police

Washington & Thompson

W. H.  
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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 4 1 3 3 6 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                            |   |  |
|---|--|--|--|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Arthur Short</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 23, 1984</b> |   | 2b. HOUR<br><b>1.40 AM</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-1-1922</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>61</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY BALTO.   |  |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Boney Short</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>250-30-5202</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Catherine Short 4414 Towanda Ave.</b>  |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                            |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Severe, recurrent gastroenteritis with Malnutrition</b>  |  |  |  |   |                            |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF SITUATION, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9/6 75</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, PUBLIC OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/23 84</b> to <b>5/23 84</b> , that (I) (we) last saw the deceased alive on <b>5/23 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |                            |   |  |
| 22b. SIGNATURE<br><b>D. W. STEWART</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |                            | 22c. DATE SIGNED<br><b>5/25/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. W. STEWART</b>   |  |  |  | 22e. ADDRESS<br><b>2300 Garrison Blvd. (21216)</b>  |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-29-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat. Mem Park</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, P.G. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA</b>   |  |  |  | ADDRESS<br><b>1300 Eutaw Pl</b>   |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1984</b>   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                            |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |  |
|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Iva E. Shuemate</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 2, 1984</b>               |  | 2b. HOUR<br>M<br><b>M</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 26 19</b>                                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>64</b>                     |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cyrus W. Handy Briddell</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Raymond Timmons</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>215-14-3378</b>                          |  | 17. INFORMANT<br>ADDRESS<br><b>John B. Shuemate, Sr. 815 Richwood Ave</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <b>1976</b> to <b>Apr 1984</b> , that (1) (we) last saw the deceased alive on <b>Apr 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>I Ched</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   | 22c. DATE SIGNED<br><b>5-4-84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ISSAM E CHEIKH M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>Union Mem Hosp</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/7/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |  | ADDRESS<br><b>1101 E North Avenue</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1984</b>                                   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>  |  |   |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





Item 3,4,5,13a, b, for e, 14,15 per, ph. 6/15/84

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BABY BOY SHULKA</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 26, 1984</b>             |   |  | 2b. HOUR <b>9:26</b> P  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 26 1984</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.  |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13a. COUNTY <b>Balto</b>   |  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE <b>1220 Halstead Rd. 21234</b> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Phillip Shulka</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margret Shulka</b> |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7651 IMMEDIATE CAUSE (a) CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PREMATURITY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hours</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> 19 <b>84</b> , to <b>5/26</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE <b>1. Bergstrom</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED <b>5/26/84</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN K. BERGSTROM</b>   |  |  |  | 22e. ADDRESS <b>550 N. BROADWAY, BALTO. MD.</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE <b>05/27/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>HOSP. BALTIMORE MD.</b>                |   |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D BY REGISTRAR <b>JUN 1 1 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>                          |   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

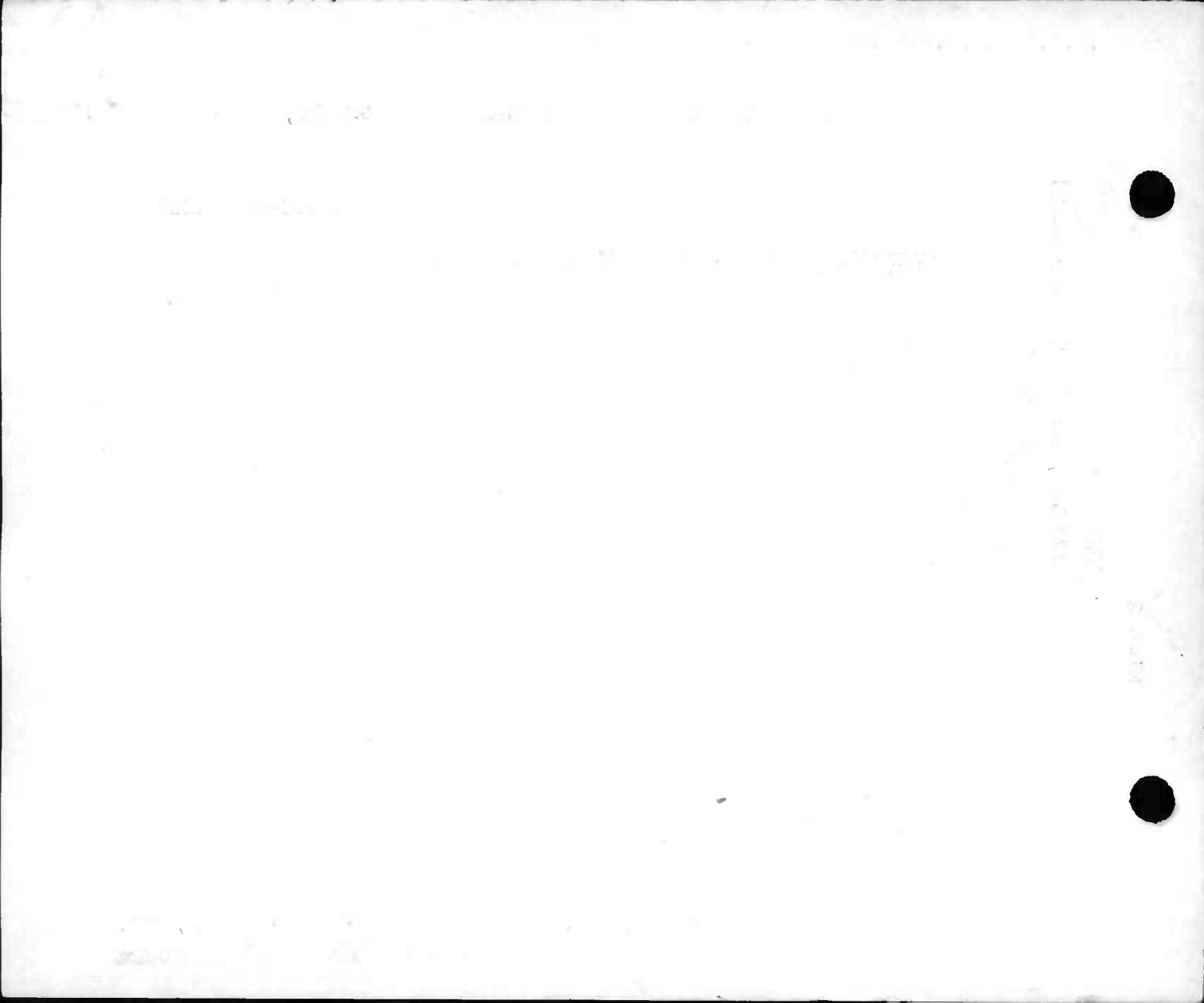
NICU 2

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial. **SHULKA, BABY BOY (MARGARET)**  
IMPORTANT: If item 21 is marked as "18 shows any injury, or other traumatic event," the medical examiner must be notified and a source of information must be provided.

210-90-68

05/26/84



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |   | REG. NO.  |  |
|--|--|--|--|---|--|---|--|--|---|---|--|
| FOR Items 18-22a 10/11/84  |  |  |  |   |  |   |  |  |   | 13370   |  |
| 1- REGISTRAR F#596   |  |  |  |   |  |   |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOSEPH Ralph SIDERCHUK  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>5-23-84  |  |  | 2b. HOUR<br>M<br>4:55A                                      |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 19, 1950         |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>33 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-23-84                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Longshoreman   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS<br>313 E. Cross St. Balto. Md. 21230    |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                              |  |   |  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony SIDERCHUK  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marguerite A. Clarke   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>212-56-9162                     |  | 17. INFORMANT ADDRESS<br>Mrs. Marguerite A. Fischer, Same as above  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <u>Alcoholism</u>   |  |  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____   |  |  |  |   |  |   |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |  |   |   |  |
| ACTUAL SIGNATURE <u>Marguerite A. Korell</u>   |  |  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  | DATE SIGNED 5-23-84   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.  |  |  |  |   |  | ADDRESS 111 Penn Street   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>May 25, 1984                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore, Maryland |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>McUllly Funeral Home, 130 E. Fort Ave. Balto. Md. 21230  |  |  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>MAY 28 1984   |  |  | 25b. REGISTRAR'S SIGNATURE                                  |   |  |



OLD DIRECT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                      |   |  |   |  |                               |  |
|---|--|--|---|---|----------------------|---|--|---|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IDA MAE SIEGLEIN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 9 84 |   | 2b. HOUR<br>10:27 AM |   |  |   |  |                               |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 25 23  |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   |   |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---  |  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Arbutus  |  |  |   |   |                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4200 Ridge Drive 21229  |  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN HARDY  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MOLLIE PAINTER   |                      |   |  |   |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>236-22-5135  |   | 17. INFORMANT<br>George Sieglein  |                      |   |  | ADDRESS<br>4200 Ridge Dr. 21229   |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC LUNG CANCER.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Rise than 5 min</u><br><u>2 YEARS</u> |  |  |   |   |                      |   |  |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>NONE</u>  |  |  |   |   |                      |   |  |   |  |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                      |   |  |   |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |   |  |   |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> , 19 <u>84</u> , to <u>5/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |                      |   |  |   |  |                               |  |
| 22b. SIGNATURE<br><u>Peter L. Kennedy, M.D.</u>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                      |   |  | 22c. DATE SIGNED<br><u>5/9/84.</u>  |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PETER L. KENNEDY, M.D.</u>  |  |  |   | 22e. ADDRESS<br><u>UNIVERSITY HOSP.</u>   |                      |   |  |   |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/12/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |   |  |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  |  |   | ADDRESS<br>4107 Wilkens Ave.  |                      | 25a. DATE REC'D. BY REGISTRAR<br>MAY 11 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendell</u>   |  |                               |  |

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1964



*[Faint, mostly illegible text and markings covering the main body of the page. Some words like "RECEIVED" and "JAN 10 1964" are visible at the top.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#166 per F.H. 6/18/84 km  
FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 7 2

REG. NO.

|  |  |  |   |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLARA GERTRUDE SILVA</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 23 84</b> |  |  | 2b. HOUR<br><b>120 AM</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 31 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>   |  | 8b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SPINNER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TEXTILE</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |   | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>2601 WESTCHESTER AVE. 21043</b>                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES JEREMIAH KELLEY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GERTRUDE VIRGINIA THOMPSON</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-18-6192</b>   |  |
| 17. INFORMANT<br><b>ANITA MURKIN</b>   |  |  |   | 17a. ADDRESS<br><b>2306 WESTCHESTER AV.<br/>CATONSVILLE, MD 21228</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) Respiratory arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cancer of lung</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>COPD, Cor pulmonale</b>   |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>5/23/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/20/84</b> to <b>5/23/84</b> , that (I) (we) last saw the deceased alive <b>at 1:20 AM</b> on <b>5/23/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Singh</b>   |  |  |   | DEGREE   |  |  |  | 22c. DATE SIGNED<br><b>5/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. SINGH MD.</b>   |  |  |   | 22e. ADDRESS<br><b>900 Caton Ave. St. Agnes Hospital<br/>Baltimore, MD 21229</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-25-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELK RIDGE HOWARD MD.</b>            |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>SLACK FUNERAL HOME</b>  |  |  |   | 24a. ADDRESS<br><b>Box 268<br/>ELK RIDGE CITY MD 21043</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, the primary injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/B2  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |   |   |  |
|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLEN</b>  |   | MIDDLE <b>M. Neel</b> LAST <b>SIMPSON</b>   |  |
| 2a. DATE OF DEATH<br><b>MAY 2, 1984</b>   |   | 2b. HOUR<br><b>11:55A</b> M   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>Aug.</b> DAY <b>9,</b> YEAR <b>1897</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 13e. STREET ADDRESS<br><b>4416 Marble Hall Rd. 21218</b>  | 14. FATHER'S NAME<br>FIRST <b>J.</b> MIDDLE <b>Wilbur</b> LAST <b>Neel Sr.</b>  |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Flora</b> MIDDLE <b>Marshall</b> LAST <b>Marshall</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |
| 16b. SOCIAL SECURITY NO.<br><b>214-40-4089A</b>   |   | 17. INFORMANT<br>ADDRESS <b>Wash., D.C. 20002</b><br><b>Mr. W.K. Marshall Simpson 216 11th St. N.E.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 2,</b> 19 <b>1984</b> , to <b>MAY 2,</b> 19 <b>1984</b> , that (I) (we) last saw the deceased alive on <b>MAY 2,</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.            |   |   |  |
| SIGNATURE<br><b>Donald W. Mintzer M.D.</b>  |   | DEGREE<br><b>M.D.</b>   | DATE SIGNED<br><b>5/2/84</b>   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONALD W. MINTZER</b>   |   | 22c. ADDRESS<br><b>3009 EVERGREEN AVE BALTIMORE</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>5-3-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Indian Mound</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Romney Hampshire Va.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>  |   | ADDRESS<br><b>6500 York Road 21212</b>  |  |
| MAY 7 1984  |   | MAY 7 1984  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.13  
1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |                                       |   |   |  |  |
|---|--|---|---|---|---------------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Adell Sims</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 7 1984</b>              |   |                                       | 2b. HOUR<br>M<br><b>11</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 10 1922</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>61</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2410 W. Coldspring Lane</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Textile Worker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>S. Schapiro &amp; Sons</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                       |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jim Hayes</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susie Veasley</b> |   |                                       | 16. ADDRESS<br><b>21215</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>252 28 7790</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy S. Sneed 2410 W. Coldspring Lane</b>   |                                       |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Nodular Lymphoma (Dx From Recnd)</b><br><b>2020</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |                                       |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:   |  |   |   |   |                                       |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                       |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 14</b> , 19 <b>84</b> , to <b>Present</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>April 28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.     |  |   |   |   |                                       |   |   |  |  |
| 22b. SIGNATURE<br><b>Sheldon Goldgeier</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                       |   |   | 22c. DATE SIGNED<br><b>5/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS  |                                       |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/12/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                        |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Nutter and Sons</b><br><b>Funeral Home, Inc.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>   |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randell</b>                                |   |  |  |

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Reparations

## Discussion

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
|  |  | Hyman Singer  |  | 5-25-84  |  | 10:20 P.M.  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | White   |  | SEP 15, 1897<br>XX - 05 - 1897   |  | 86 YRS.   |  |
| 7. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| LITHUANIA  |  | U.S.A.  |  |  |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | Levindale   |  | MERCHANT   |  | RETAIL  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND   |  |   |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS / ZIP CODE   |  |   |  |
| ISAAC  |  | HATTIE  |  | 6320 GREENSPRING AVE. (21209) T  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |
| NO   |  | 218-10-4124   |  | MRS. DORA GLASSMAN   |  | APT. TA6 (21209)<br>6320 GREENSPRING AVE.                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-5-80, 19 80, to 5-25, 19 84, that (I) (we) last saw the deceased alive on 5-25, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Ely  |  |   |  | DEGREE M-D<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br>5-26-84.  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SEI HTWAR   |  |   |  | 22e. ADDRESS<br>Levindale 21215<br>2434 Belverdere Ave Balto, Md   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| BURIAL   |  | 5/27/84   |  | ANSHE NEISEN CEM   |  | ROSEDALE BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  | MAY 31 1984  |  |   |  |

1

19/05/11 004 APR 20 11

DATE 11-05-11  
PAGE 1  
TIME 11:00  
FILE 11-05-11

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*[Faint, mostly illegible text and markings covering the main body of the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RAY</b> <sup>FIRST</sup> <b>SINGER</b> <sup>MIDDLE</sup> <b>XXXXXX</b> <sup>LAST</sup>   |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>10</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>3:15 AM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>9</b> YEAR <b>00</b>                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b> YRS. MONTHS <b>9</b> DAYS <b>1</b> HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SYNAI HOSPITAL OF BALTO.</b>          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY OF BALTIMORE MD.</b>                         |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR BUSINESS)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  | 13a. STREET ADDRESS, ZIP CODE<br><b>APT. 302 (21215) 7121 Park Heights Ave.</b>              |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO. CITY</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>ISAAC</b> MIDDLE LAST <b>GOLDBERG</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>REBECCA</b> MIDDLE LAST <b>BUCKNER</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>               |  |
| 16b. SOCIAL SECURITY NO.<br><b>215284482</b>  |  | 17. INFORMANT<br><b>MR. BERNARD SINGER</b>  |  | ADDRESS<br><b>APT. 302 (21215) 7121 PARK HEIGHTS AVE</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b><br><b>5621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis / Small bowel perforation 4 days</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diberculosis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diberculosis</b> |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>5/6/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Small bowel perforation</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>84</b> , to <b>5/10</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Marc Siegelbaum MD</b>   |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC SIEGELBAUM MD</b>  |  | 22e. ADDRESS<br><b>SYNAI HOSP. OF BALTO. 21215</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/11/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MENS CEM</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  | 24. FUNERAL DIRECTOR'S NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  |
| 24. ADDRESS<br><b>6010 REISTERSTOWN RD BALTIMORE, MARYLAND 21215</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |





# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                           |  |
|--|--|--|--|---|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GROVER MATTHEW SIZEMORE JR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-2-84</b> |   | 2b. HOUR<br><b>11 A M</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 10 31</b>   |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                           |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>   |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ROOFER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ROOFING</b>  |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |                           |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GROVER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE CALLAHAN</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |                           |  |
| 17. SOCIAL SECURITY NO.<br><b>214-26-8395</b>  |  | 18. INFORMANT<br><b>MARY LEE SIZEMORE</b>  |  | 19. ADDRESS<br><b>120 S. MONROE ST. 21223</b>   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypercalcemia.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Adenocarcinoma of Lung c multiple</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>metastasis to Brain, Liver, Bone.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>carcinoma of larynx 3/P Tracheostomy.</b> |  |  |  |   |                           |  |
| 19a. DATE OF OPERATION<br><b>1629</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>1629</b>  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           |  |
| 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-6-19-84</b> to <b>5-2-19-84</b> that (I) (we) last saw the deceased alive on <b>5-2-19-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                           |  |
| 22b. SIGNATURE<br><b>ADILKUMAR. RAIKER</b>   |  | DEGREE<br><b>MD.</b>   |  | 22c. DATE SIGNED<br><b>5-2-84</b>   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ADILKUMAR. RAIKER</b>  |  | 22e. ADDRESS<br><b>U. M. C. C. Balto. MD.</b>  |  |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>05-05-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1984</b>  |                           |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John R. Rindell</b>   |  |  |  |   |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or checked, show injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JACK SKOLNIK  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 6 84                          |   |  | 2b. HOUR<br>P. M.<br>3:35   |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASION  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 15 98   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>COUNTRY<br>ROMANIA<br>XXXXXXXX  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY OF BALTIMORE MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI Hosp |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK DURING LIFE)<br>XXXXXXXXXX                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>1  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>400 CLARKS LANE APT. 501 21215   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN SKOLNIK   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>19-32-0688   |   |  |  |  |
| 16c. ADDRESS<br>ANNA SKOLNIK 4001 CLARKS LANE APT. 501 (21215)<br>XXXXXX XXXXXXXXXXXXX  |  |   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC Arrest<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PNEUMONIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-17, 19 84, to 5-6, 19 84, that (I) (we) lost<br>saw the deceased alive on 5-6, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Woodie Heron MD   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>5-6-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Woodie Heron   |  |   |  |   | 22e. ADDRESS<br>Sinai Hosp. Belvedere / Greenspring  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL<br>XXXXXXXXXXXX  |  |   | 23b. DATE<br>5/8/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH CEM  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall              |  |  |

MEDICAL CERTIFICATION

*[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side. Includes a circled 'A' in the top right corner and two punch holes on the right edge.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

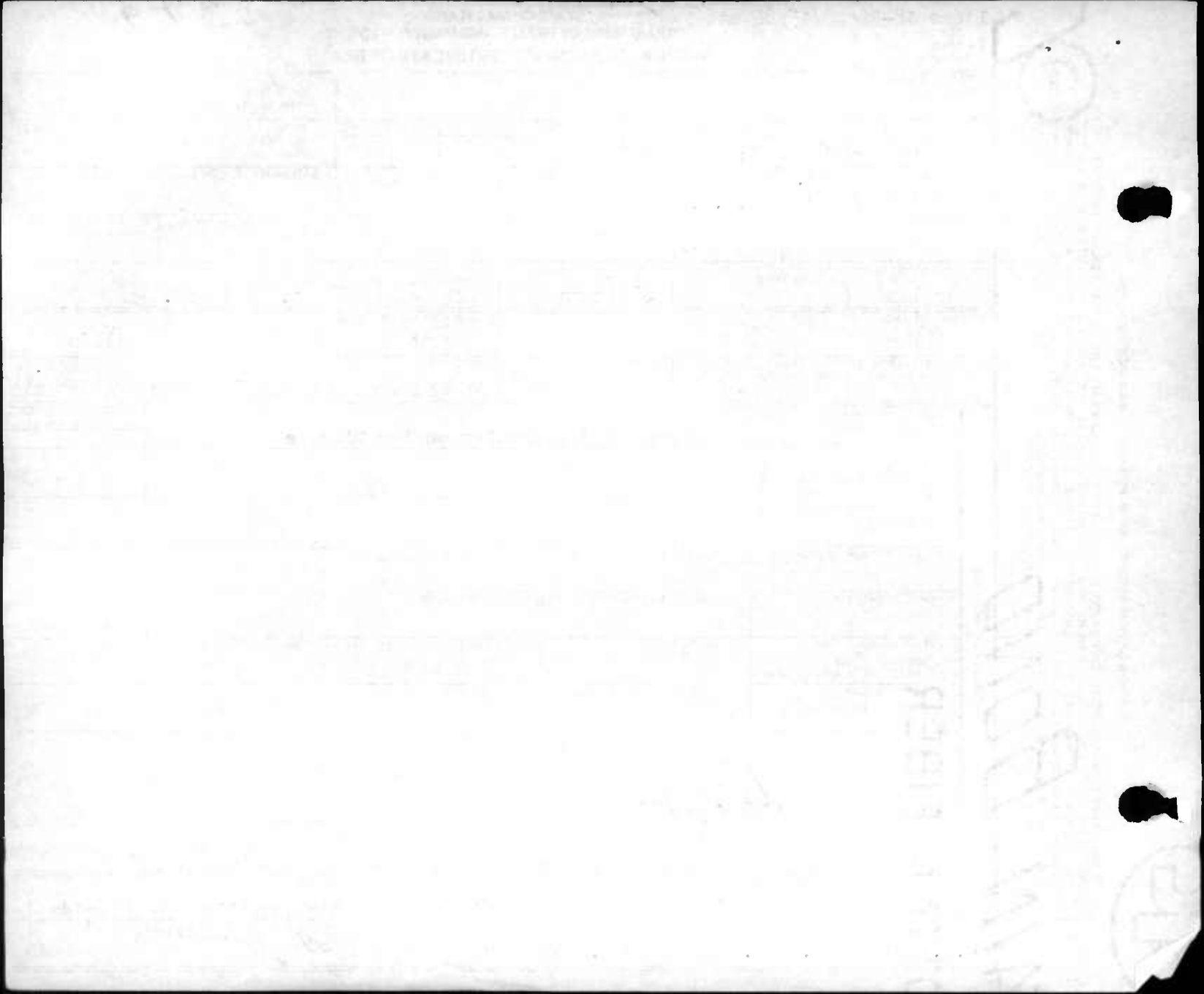
Items 18-22a 6/15/84 mtb R#592

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |                  |   |                |                  |  |  |  |   |  |  |
|--|---------|------------------|---|----------------|------------------|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | FIRST MIDDLE LAST   |                |                  | 2a. DATE KNOWN OF DEATH  |  |  | 2b. HOUR  |  |  |
| DELORES  |         |                  | SLOAN   |                |                  | EST. MATED <input checked="" type="checkbox"/> 5/9/84 19   |  |  | M   |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD   |  |  | 24 HOUR   |  |  |
| Female   | Black   | 11 24 1937       | 46 YRS.   | MONTHS         | DAYS             | 5/9/84 19  |  |  | 9:15 P M  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7d. CITIZEN OF WHAT COUNTRY?  |                |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| f Jacksonville   |         |                  | U.S.A.  |                |                  | Baltimore City   |  |  | MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Baltimore  |         |                  | 1837 Eagle St.  |                |                  |  |  |  |   |  |  |
| 13a. STATE   |         |                  | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN  |  |  | 13d. STREET ADDRESS   |  |  |
| Maryland   |         |                  |   |                |                  | Baltimore  |  |  | 1837 S. Eagle St. 21223   |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME  |                |                  |  |  |  |   |  |  |
| Allen  |         |                  | Ruth  |                |                  |  |  |  | Phillips  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |                  | 16b. SOCIAL SECURITY NO.  |                |                  | 17. INFORMANT  |  |  | ADDRESS   |  |  |
|  |         |                  |   |                |                  | Bobby Lang   |  |  | 3106 Rackley Drive Tallahassee Fla.                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                  |   |                |                  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |                  |   |                |                  |  |  |  |   |  |  |
| 4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease   |         |                  |   |                |                  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |   |                |                  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |                  |   |                |                  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |   |                |                  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |   |                |                  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                  |   |                |                  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                |                  |  |  |  | 20. AUTOPSY?  |  |  |
|  |         |                  |   |                |                  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |
|  |         |                  | P.M. 19   |                |                  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                |                  | 21f. LOCATION  |  |  |   |  |  |
|  |         |                  |   |                |                  | CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |   |                |                  |  |  |  |   |  |  |
| ACTUAL SIGNATURE   |         |                  | TITLE (SPECIFY)   |                |                  |  |  |  | DATE SIGNED   |  |  |
| [Signature]  |         |                  | M.D. Assistant MEDICAL EXAMINER   |                |                  |  |  |  | 5/10/84   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  | ADDRESS   |                |                  |  |  |  |   |  |  |
| Gregory R. Kauffman, M.D.  |         |                  | 111 Penn St., Balto., Md. 21201   |                |                  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 23b. DATE   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |
| Burial   |         |                  | 5/18/84   |                |                  | Greenwood Cemetery   |  |  | Jacksonville Florida  |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |                  | ADDRESS   |                |                  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Wm. C. Brown Comm. Fun. Home   |         |                  | 1206 W. North Ave   |                |                  | MAY 21 1984  |  |  | [Signature]   |  |  |

BP 705



BP

DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Alvin L. Smith Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 29, 1984</b>   |   | 2b. HOUR<br>M<br><b>M</b>                                     |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 9 16</b>  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                           |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>  |  |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3606 Springdale Avenue</b> |   |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY  |   |   |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 13e. STREET ADDRESS<br><b>3606 Springdale Avenue</b>  |  |  | 21216  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Melvin Smith</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Toomey</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-05-5288</b>  |   |   |  |
| 17. INFORMANT<br>ADDRESS<br><b>Mary E. Smith 3606 Springdale Avenue</b>   |  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1950 IMMEDIATE CAUSE (a) Metastatic Carcinoma of the prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1981</b> , 19____, to <b>May</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Arthur A. Serpuk</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/30/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur A. Serpuk</b>  |  | 22e. ADDRESS<br><b>Saint Joseph Hosp Town MD 21204</b>                 |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>6/2/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co, Md.</b>  |  |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>   |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |  |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ARTHUR W. SMITH</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 02 1984</b> |   |  | 2b. HOUR<br>M<br><b>AM</b>  |  |
| 1. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG 17 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>MARYLAND</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DUKELAND NURSING HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>custodian</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pratt Library</b>                                       |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elias Smith</b>                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda Williams</b>   |   | 17. INFORMANT ADDRESS<br><b>2813 Brighton Street</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>   |   | 17. INFORMANT ADDRESS<br><b>2813 Brighton Street</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **STROKE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

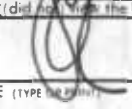
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
HOURS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**COPD**

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from <b>29 DEC</b> , 19 <b>83</b> , to <b>02 MAY</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>02 MAY</b> , 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not see the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>02 MAY 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR M. LEBSON, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>3640 FORDS LANE BALTIMORE 21215</b>  |  |   |  |

|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/7/1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR <b>Nutter &amp; Sons Funeral Home Inc.</b><br>NAME ADDRESS<br><b>2501 Gwynns Falls Parkwy. Baltimore, Md. 21216</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1984</b>                   |  |  |  |



88

Guatán

2012 Bridge Street  
Baltimore, Maryland 21218  
NW II NW II  
Sharon  
William

2801 Gwynns Falls Parkway, Baltimore, MD 21216 (NW) 4  
Nutter & Sons General Home Inc.  
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate may be further completed.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CARRIE</b> FIRST <b>SMITH</b> LAST  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>5/14/84</b> |  |  | 2b. HOUR <b>10<sup>35</sup></b> MIN  |  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Caucasian</b>  |   | 5. DATE OF BIRTH MONTH DAY <b>1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO. MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FEDERAL HILL NURSING CENTER</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE <b>1213 LIGHT ST. 21230</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST      |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. <b>213-54-1888T</b>  |   | 17. INFORMANT <b>Pt.'s chart</b>   |  | ADDRESS  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>SENILE DEMENTIA OF THE ALZHEIMER'S TYPE</b>   |  |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 1</b> , 19 <b>83</b> , to <b>MAY 15</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>MAY 1</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE <b>George J. Taler, M.D.</b>  |  |   |   | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>5/15/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE TALER, M.D.</b>  |  |   |   | 22e. ADDRESS <b>600 LIGHT ST. BALTO. MD. 21230</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Ed. Cunniff</b> ADDRESS <b>1712 W. North Ave.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>   |  |   |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

Items 18 6/20/84 mtb F#592

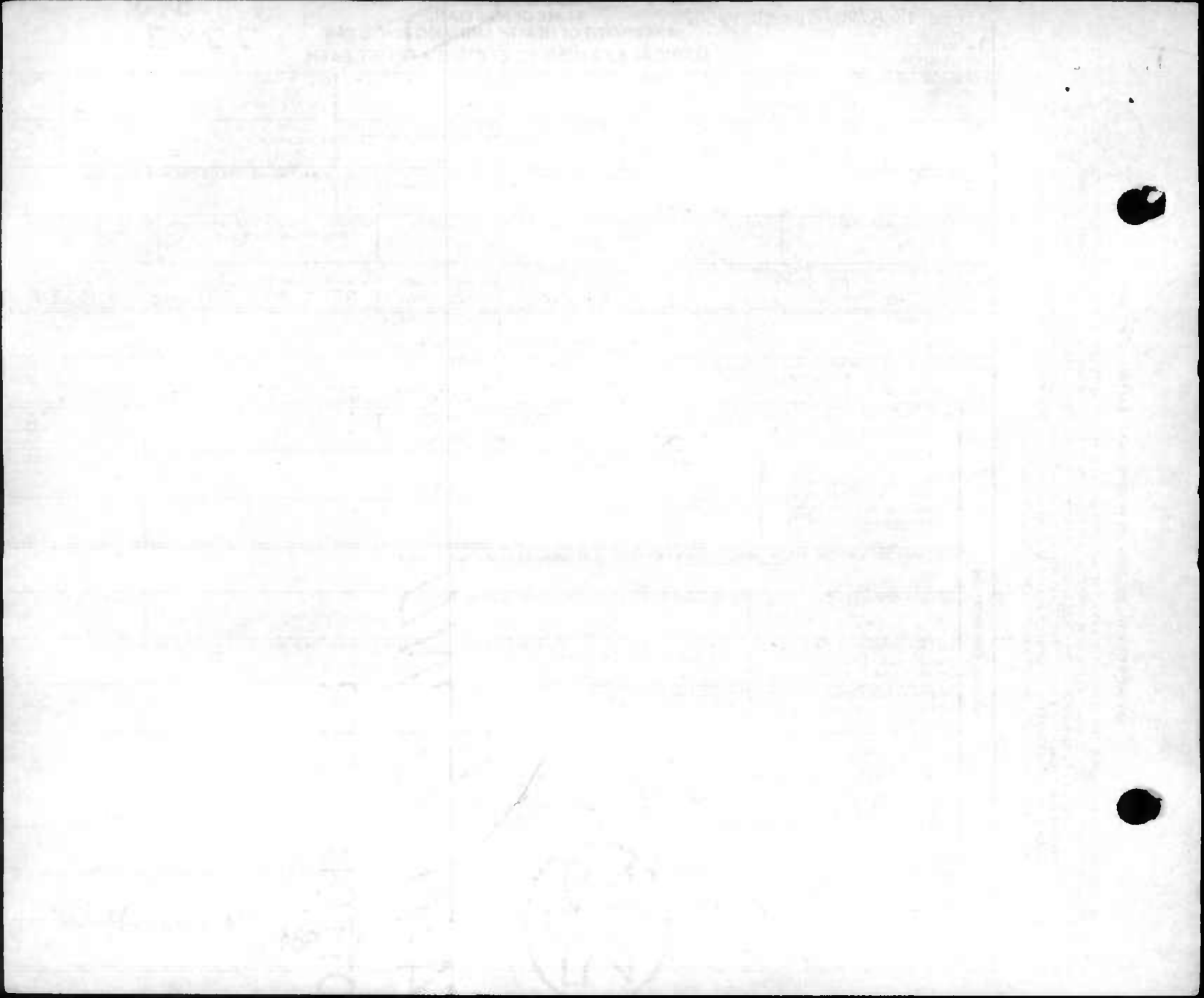
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |  |   |   |
|--|-------------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dante (Donte) L. Smith</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>EST. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 7 1984</b> |   | 2b. HOUR<br>M <b>6:38A</b>  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 15 84</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>3</b>                                | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 7 1984</b>  | 7d. HOUR<br>M <b>6:38A</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD  |                         |  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |                         |  |  |   |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  |  |   |   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY             | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          | 13e. STREET ADDRESS<br><b>2701 The Alameda 21218</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frazier Gibson</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Veronica Smith</b>                                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Veronica Smith 2701 The Alameda</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4850 Sudden Infant Death Syndrome</b><br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |  |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |   |   |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |  | DATE SIGNED<br><b>5/7/84</b>  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St. Balto., MD.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>5/10/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Memorial Pk Baltimore,</b> MD   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>   |                         | ADDRESS<br><b>1101 E North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1984</b>   |   |

STATE

MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ETHEL G. SMITH  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-30-84                     |   |   | 2b. HOUR<br>12:54 PM   |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 24 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                        |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt. City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Manf. Co.                   |  |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>1716 McHenry Street 21223  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John J. Evans   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth Ann Whitcomb |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-30-4832  |  | 17. INFORMANT<br>ADDRESS<br>Loretta R. Smith 815 Wellington St. 21211   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE INFERIOR MYOCARDIAL INFARCTION</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ISCHAEMIC HEART DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Hour |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS, ACIDOSIS, HYPERKALAEMIA.</u>   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/30/84</u> , 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>5/30/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Abhok Kumar Chopra M.B.B.S.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>5/30/84</u>                               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. K. CHOPRA   |  |   |  | 22e. ADDRESS<br>3455 WILKENS AVE<br>BALTO MD 21229  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>6/2/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  | ADDRESS<br>21229<br>4107 Wilkens Ave.   |  | DATE REC'D. BY REGISTRAR<br>JUN 1 1984  |   | REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>            |  |  |  |

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ITEMS 18-22a 7/3/84 mtb #593

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 3 3 8 5

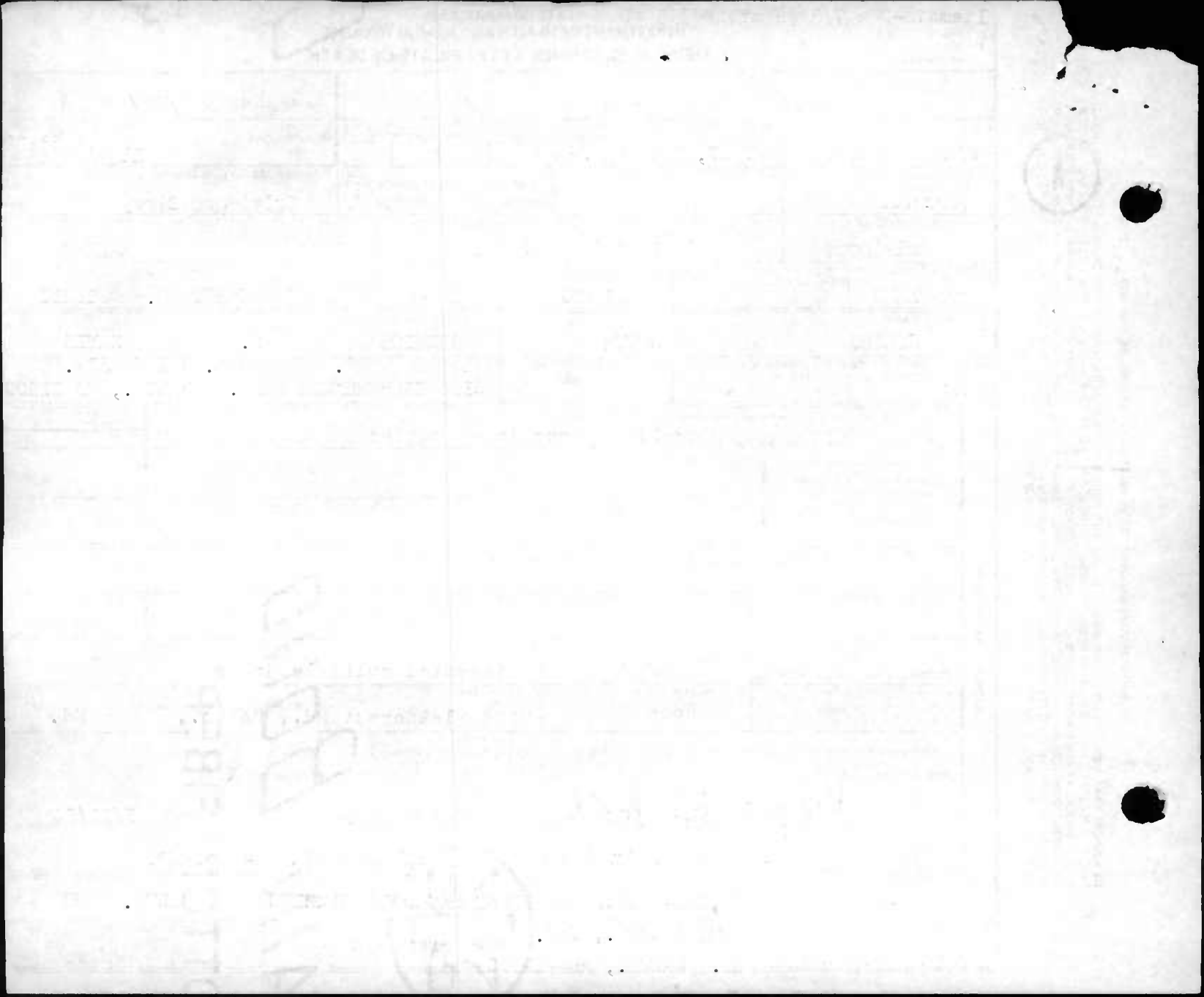
1- STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |             |  |  |   |   |   |  |   |
|--|-------------|--|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |             |  | 2a. DATE KNOWN<br>OF DEATH   |   |   | 2b. HOUR  |  |   |
| Frank ROGER Smith  |             |  | ESTIMATED <input checked="" type="checkbox"/> 5/20/84                  |   |   | M   |  |   |
| 3. SEX   | 4. RACE     | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.  | 7c. DATE<br>PRONOUNCED  | 7d. HOUR                                   |   |
| MALE   | WHITE       | MAY 27, 1949   | 34 YRS.  | MONTHS  | DAYS  | DEAD  | 11:20                                      |   |
| 8. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |             | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                    |  |   |
| MARYLAND   |             | USA  |  |   |   | Baltimore City, MD.   |  |   |
| 11. CITY OR TOWN OF DEATH  |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12b. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)        |  | 12c. KIND OF BUSINESS<br>OR INDUSTRY                                |
| Baltimore  |             | 7003 Fieldcrest Rd.  |  |   |   | BAKER   |  | BAKING  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |             |  |  |   |   |   |  |   |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |  |   |
| MARYLAND   |             | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 7003 FIELDCREST RD. 21215   |   |  |   |
| 4. FATHER'S NAME   |             |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |   |
| FIRST MIDDLE LAST<br>JULIUS SMITH  |             |  | FIRST MIDDLE LAST<br>BERNICE S. MERVIS                                 |   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |             |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT   |  |   |
| NO   |             |  |  |   |   | MRS. BERNICE S. SMITH APT. C<br>6156 GREENMEADOW PKWY. BALTO., MD 21209 |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |             |  |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |
| IMMEDIATE CAUSE (a) Combined drug intoxication   |             |  |  |   |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |             |  |  |   |   |   |  |   |
| (b)  |             |  |  |   |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |             |  |  |   |   |   |  |   |
| (c)  |             |  |  |   |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |             |  |  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |   |   |  | 20. AUTOPSY?  |
|  |             |  |  |   |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 5/2/84 19      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |   |  |   |
|  |             |  |  |   | ingested multiple drugs   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>   |             |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>7003 Fieldcrest Rd., Balto., Md. |   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion<br>death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> . |             |  |  |   |   |   |  |   |
| ACTUAL<br>SIGNATURE  |             |  | TITLE (SPECIFY)  |   |   | DATE<br>SIGNED  |  |   |
| Margarita A. Korell  |             |  | Assistant  |   |   | 5/21/84   |  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |             |  | ADDRESS  |   |   |   |  |   |
| Margarita A. Korell, M.D.  |             |  | 111 Penn St. Balto., MD.   |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |             |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |
| BURIAL   |             |  | MAY 23, 1984   |   | BETH HAMEDROSH HAGODOL  |   | ROSEDALE BALTO. MD                         |   |
| 24. FUNERAL DIRECTOR<br>NAME   |             |  | 25a. DATE REC'D BY REGISTRAR   |   |   | 25b. REGISTRAR'S SIGNATURE  |  |   |
| SOL LEVINSON & BROS., INC.   |             |  | MAY 25 1984  |   |   | Julia Davidson-Randall  |  |   |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |             |  |  |   |   |   |  |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.   |   |
|--|--|---|--|---|--|---|
| 1. FOR STATE REGISTRAR   |  |   | 1. DECEASED NAME<br>(TYPE OR PRINT)        |   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |
|  |  |   | George H. Smith                            |   | May, 22, 1984  |   |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |
| Male   |  | White   |  | Dec. 26, 1919   |  | 64 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |
| Maryland   |  | USA   |  |   |  | Baltimore City MD.  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Baltimore  |  | 1217 William St. Balto. Md. 21230   |  | Truck Driver  |  | A.A.A.  |
| 13a. STATE   |  |   | 13b. COUNTY                                | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| Maryland   |  |   |  | Baltimore   | 13e. STREET ADDRESS / ZIP CODE   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |   |  |   |
| Walter ---- Smith  |  |   | Laura ---- McNally                         |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.                   |   | 17. INFORMANT ADDRESS  |   |
| No   |  |   | 216-18-9300                                |   | Mrs. Elizabeth F. Smith, Same as above   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Lung Cancer - metastatic to brain<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                       |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 83, to May 19 84, that (I) (we) last saw the deceased alive on 3/26 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |
| 22b. SIGNATURE DEGREE  |  |   |  | 22c. DATE SIGNED  |  |   |
| Patrick W. White M.D.  |  |   |  | 5/23/84   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |   |
| Patrick W. White   |  |   |  | 299 Frederick Rd., Balt., Md.   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |
| Burial   |  | May 26, 1984  |  | Cedar Hill Cemetery   |  | Baltimore, Maryland   |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |
| McCully Funeral Home, 130 E. Fort Ave. Balto. Md.  |  |   |  | MAY 28 1984   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |   |
|--|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST<br>HILDA  | MIDDLE  | LAST<br>GRANDPRE   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 8 84  | 2b. HOUR<br>6:17 PM   |
| 3. SEX<br>FEMALE   | 4. RACE<br>NEGRO  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 30 12  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                              |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General Hospital |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLEANER/RETIRED  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOSPITAL  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |   |
| 13a. STATE<br>MD   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2903 The Alameda 21218  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Holland  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa Diggs   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-07-1229  |   | 17. INFORMANT<br>ADDRESS<br>Larry Grandpre 2903 Alameda 21218                        |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4860 IMMEDIATE CAUSE (a) PNEUMONIA / Septis  |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Caden Directly mechanism of death: Thoracic Aorta  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 4:29, 19 84, to 5:18, 19 84, that (I) (we) lost saw the deceased alive on 5/8 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |   |
| 22b. SIGNATURE<br>MBBS, MACP   |   | 22c. ADDRESS<br>North Charles General Hosp.<br>N. Charles & 23rd St. Balto, Md 21209.   |   |  | 22d. DATE SIGNED<br>5/8/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. HORRIGAN  |   |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE INSTRUCTIONS)<br>BURIAL  |   | 23b. DATE<br>5/14/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown, Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 10 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall            |

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*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |                            |   |  |
|---|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KATHRIN W. SMITH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 6 84</b> |   | 2b. HOUR<br><b>1:45 AM</b> |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-4-1905</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>78</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |                            |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |                            |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward K. Huppert</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cecilia</b>   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. (IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS<br><b>Charles W. Smith - 5008 Annapolis Ave. - 21206</b>   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY: <b>Congestive Heart Failure</b><br>IMMEDIATE CAUSE (a) <b>5789</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Multiple MI's</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple MI's</b>  |  |   |  |   |                            |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>GI bleed / Perit vascular disease / Renal Failure</b>   |  |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION<br><b>4/14/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GI Bleeding</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/6 19 84</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/6</b> 19 <b>84</b> to <b>5/6</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                            |   |  |
| 22b. SIGNATURE<br><b>Paul Miller</b>  |  |   |  | DEGREE<br><b>MD</b>   |                            | 22c. DATE SIGNED<br><b>5/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL MILLER M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-9-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc. - 6415 Belair Rd. - 21206</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |                            |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |                            |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Female

White

8-4-1907

78

Balto. Md.

U.S.A.

x

Home Worker

3781 Gleney Ave. - 21513

x

Balto.

Md.

Edmund K. Huppert

Cecilia

215-50-7394

215-03-7030

Charles W. Smith - 2008 Antenna Ave. - 21507

Burial

7-9-84

Garden of Faith Co.

Balto. Md.

John C. Miller Inc. - 8415 Belair Rd. - 21506



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEE SMITH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/30/84</b>   |   | 2b. HOUR<br><b>1105</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/23/1915</b>                          |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>                                    |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WYMAN PARK HEALTH SYS</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER COAL HAVER</b> |  |
| 12b. KIND OF BUSINESS, OR INDUSTRY<br><b>21223</b>  |  | 13a. STATE<br><b>Md</b>   |   | 13b. COUNTY<br><b>1</b>   |  |  |
| 13c. CITY OR TOWN<br><b>BALT</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>120 S SCHROEDER ST</b>                                |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ENICK SMITH</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANE Sizemore</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR YEARS)<br><b>Yes W.W.II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212 14 3120</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Leticia Mae Smith 120 S. Schroeder St. 21223</b> |  |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cardio-respiratory failure**  
4100  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Myocardial Infarction**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(c) **Ischemic heart disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**Chronic obstructive disease & Restrictive pulm. disease**

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>         |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |

22a. I certify that (I) (his hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| 23a. SIGNATURE<br><b>F. Delgado MD</b>                           |  |  | DEGREE  |  |  | 22c. DATE SIGNED<br><b>5/30/84</b>                           |  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FERNANDO DELGADO</b> |  |  | 23c. ADDRESS<br><b>WYMAN PARK HEALTH HOSP</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALT MD</b> |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 23e. DATE<br><b>6-4-1984</b>  |  | 23f. NAME OF CEMETERY OR CREMATORY<br><b>Green Haven Cem.</b> |  | 23g. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John J. Brown &amp; Son, Inc. 901 N. Charles St. Baltimore Md.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1984</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendall</b>         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar. Both the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPROPER: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted to obtain an autopsy.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARION SMITH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 05 13 84</b>                 |   |  | 2b. HOUR<br><b>10:20 PM</b>   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 14 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitress</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Black &amp; Decker</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William D. Gross</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alverta Rawlings</b> |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>717 E. Coldspring Lane Baltimore, Maryland 21212</b> |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-12-8177</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>Alverta S. Stewart Baltimore, Md. 21212</b>   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY EDEMA / A.M.I.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>ASCVD</b> |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 minutes</b><br><b>25 minutes</b>                                      |  |
|  |  |  |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>DIABETES; UTL- CHRONIC RENAL FAILURE ; CARCINOMA OF BLADDER</b>  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>84</b> , to <b>5/13</b> , 19 <b>84</b> , that (I) (we) (they) saw the deceased alive on <b>5/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Douglas G. Martz Jr.</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>5/13/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DOUGLAS G. MARTZ JR.</b>   |  |  |  |   | 22e. ADDRESS<br><b>SINAI HOSPITAL - BALTIMORE</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>5/17/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltim ore, Maryland</b>                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons Funeral Home Inc.</b><br>ADDRESS<br><b>2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |   |   |  |  |

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2801 Gwynns Falls Hwy. Baltimore, Maryland 21216  
 Nutter & Sons Funeral Home Inc.  
 217/1984 Baltimore National Cem. Baltimore, Maryland

Burial

Baltimore National Cem. Baltimore, Maryland

Maryland

No.

214-12-8177 Alverta S. Stewart Baltimore, Md. 21212

William

D.

Cross

Alverta

Baltimore

717 E. Colde Ring La

21212

Maryland

Baltimore

X

Lane Baltimore, Maryland 21212

717 E. Colde Ring

21212

Baltimore

Sinal Hospital

Janitress

Black & Decker

Maryland

U. S. A.

X

Baltimore

INDEX

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

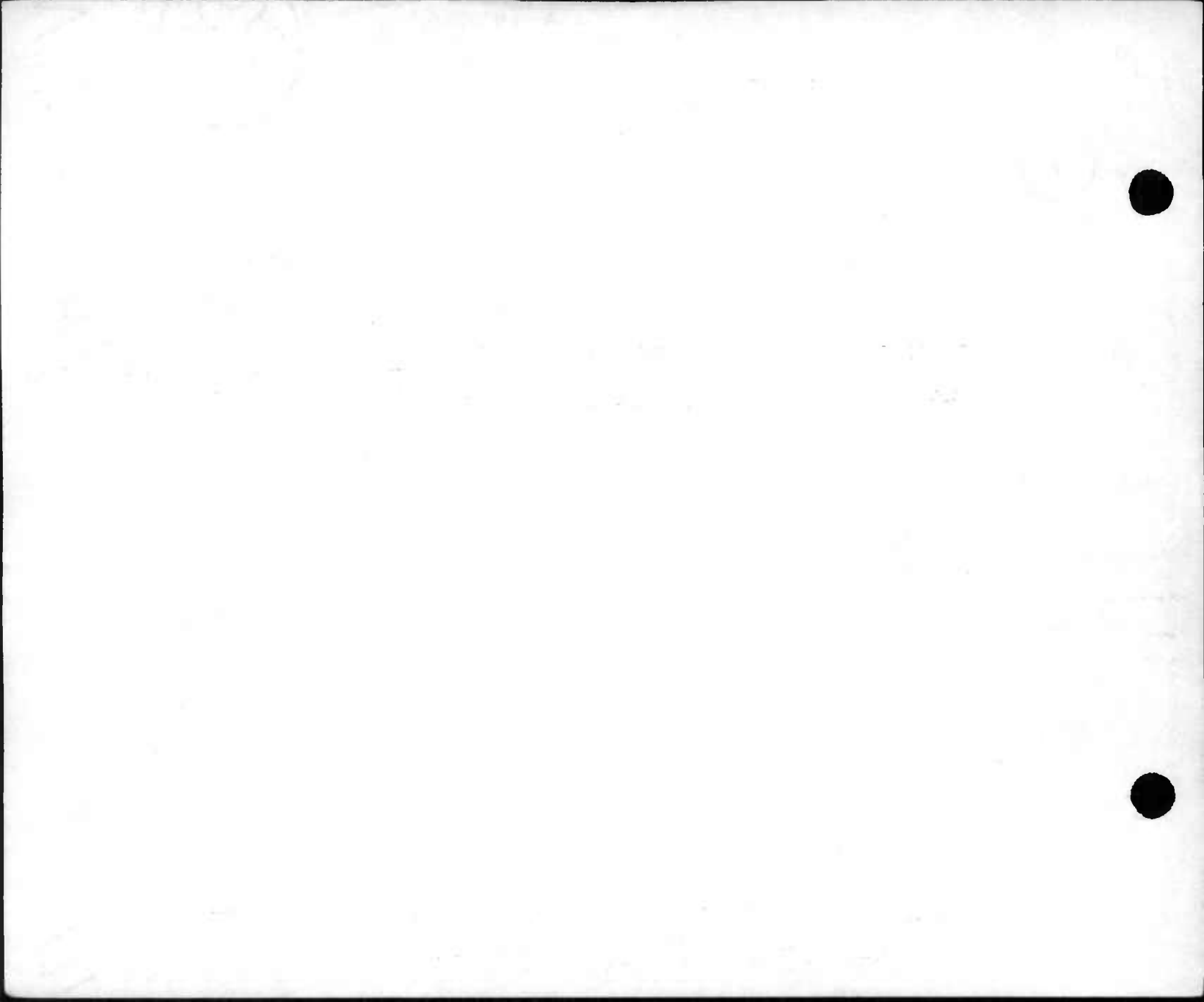
|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (AKA FIRST MARY (SMITH)<br>(TYPE OR PRINT) MARY THELMA SMITH   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>05 19 84 3:45 PM  |  |   |  | 2b. HOUR   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 05 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3635 ELMLEY AVE. 21213   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES ARMSTRONG   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA HARE  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-74-1631  |  | 17. INFORMANT<br>JACOB SMITH (SON)  |  | ADDRESS 3815 PATAPSCO AVE. 21229  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary arrest<br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) 2. Ca Pancreas, Acute MI.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) renal failure                              |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>(2) Covid 19 & multiple T.I.A.   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13, 19 84, to 5-19, 19 84, that (I) (we) lost<br>saw the deceased alive on 5-19-19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Shahida Siddiqi   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED<br>5-19-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHAHIDA SIDDIQI  |  |   |  | 22e. ADDRESS<br>Good SAMARITAN HOSPITAL   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/23/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHIMU NEK FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto Md. 21218  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's report must be filed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Released As Non-Medical By Dr. Kaufman, Per Mr. Gregory

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Paula M Smith</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05/16/84</b>  |  | 2b. HOUR<br><b>3:50P<sub>M</sub></b>  |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 22 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>70</b>                                 |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Ohio</b>  |  | 13b. COUNTY<br><b>Mahoning</b>  | 13c. CITY OR TOWN<br><b>Lake Milton</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2620 Pico Street 99999</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ludwig Moessner</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Sommer</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>-----  |  | 16b. SOCIAL SECURITY NO.<br><b>275-42-4889</b>  |  | 17. INFORMANT<br><b>Randall Smith</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4149 Intractable Pump Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Open Heart Surgery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 yrs 6 hrs</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>None</b>  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>5/16/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ISCHEMIC HEART DISEASE</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/16</b> , 19 <b>84</b> , to <b>5/16</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>G. W. AGOVER</b>  |  | DEGREE<br><b>G. W. AGOVER</b>   |  | 22c. DATE SIGNED<br><b>5/16/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. W. AGOVER</b>   |  | 22e. ADDRESS<br><b>✓</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-21-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eckis Cemetery</b>                                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Milton Township Ohio</b>  |  |   |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Marzullo Funeral Service Reisterstown, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1984</b>   |  |   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |   |

1940

1941

1942

1943

1944



Item 13e per ph 6/7/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RICHARD SMITH</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>24</b> YEAR <b>84</b>                                |   | 2b. HOUR<br><b>10:25</b>                             |
| 3. SEX<br><b>m</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>15</b> YEAR <b>97</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY - MD.</b>                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CITY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CEMENT FINISHER</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONCRETE</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>—</b> 13c. CITY OR TOWN <b>BALTO.</b> |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>FREDERICK</b> MIDDLE <b>—</b> LAST <b>SMITH</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>T</b> LAST <b>STETTLER</b>              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>W.N.I. # 218-10-4744</b>   |   | 17. INFORMANT<br>ADDRESS <b>ANNA HORST 321 N. ROBINSON ST</b> |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>0389 IMMEDIATE CAUSE (a) CARDIAC ARREST.</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION.</b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPSIS</b>  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5:24</b> 19 <b>84</b> to <b>5:24</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5:24</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) know the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Gutheil</b>   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5-24-84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gutheil</b>  |  | 22e. ADDRESS<br><b>BCH.</b>  |  |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                            | 23b. DATE<br><b>5-28-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. VET. CEM. - GARRISON</b> | 23d. LOCATION<br>CITY OR TOWN <b>GARRISON</b> COUNTY <b>MD.</b> STATE |
| 24. FUNERAL DIRECTOR<br>NAME <b>Guthrie, John</b> ADDRESS <b>- 2334 Jefferson St.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1984</b>                   | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>                      |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 8 above any injury, or other traumatic event, the medical examiner must be notified of it.

EX-100  
100-100

RECEIVED  
JAN 10 1968  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY  
FOR POLICY AND PLANNING  
MAIL ROOM  
ROOM 1000  
WASHINGTON, D.C. 20250

RECEIVED  
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U.S. DEPARTMENT OF AGRICULTURE  
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WASHINGTON, D.C. 20250

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FOR POLICY AND PLANNING  
MAIL ROOM  
ROOM 1000  
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at once)

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SYLVESTER SMITH</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 29, 1984</b>   |  | 2b. HOUR<br><b>3:36</b><br>A M   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 19 06</b>                           |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.<br>MONTHS DAYS HOURS MIN.    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Smith</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- -</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>244-10-1595</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Webb Brown 4037 Edgewood Road</b>               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4590</b> IMMEDIATE CAUSE (a) <b>Intra abdominal hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Sepsis, renal failure, Acidosis</b>   |  |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>5/26/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intra abdominal hemorrhage</b>                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/25</b> , 19 <b>84</b> , to <b>5/29</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/29/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |  |  |  |   |
| 22b. SIGNATURE<br><b>John L. Niles</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/29/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John L. Niles</b>  |  | 22e. ADDRESS<br><b>800 N. WOLFE ST. BALTO., MD. 21205</b><br><b>Johns Hopkins Hospital</b>                 |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>6/4/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem. Pk.</b>                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUN 1 1984</b> <b>John Davidson Handell</b> |  |  |   |

BP

LIBER



THE JOURNAL OF THE

NOV 2 1911

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 9 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>TRAVIS Aiden SMITH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 16, 1984</b>                           |   | 2b. HOUR<br><b>8:32</b><br>A M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 4, 1984</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. DAYS<br><b>12</b>                                       |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b><br>MD.                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dependent</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Rosedale</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mishael G. Smith</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pamela Barto</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Michael G. Smith 6 Clementine Ct. Apt 2D 21237</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>7651</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PREMATURITY</b> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MIN</b><br><b>10 DAYS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>INTRAVENTRICULAR HEMORRHAGE</b>   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>MAY 4</b> 19 <b>84</b> to <b>MAY 16</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>MAY 16</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.   |  |  |  |   |   |
| 23a. SIGNATURE<br><b>William G. Reyes, M.D.</b><br>DEGREE  |  |  |  | 23b. DATE SIGNED<br><b>5-16-84</b>  |   |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM G. KEYES</b>  |  |  |  | 25. ADDRESS<br><b>600 N. WOLFE ST. BALTO MD 21205</b><br><b>JOHNS HOPKINS HOSP</b>              |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/18/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>                                 |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. RUCK Inc 5305 Harford Rd 21214</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 18 1984</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, even if the medical examiner has been notified, the medical examiner must be notified.

01/06/01  
89010-2011H' 89V-LY2E

1 STD PO 85

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 3 9 6

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Waya Marjorie Smith<br>WNA M. SMITH   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 2, 1984 |   |  | 2b. HOUR<br>642 PM   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8, 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Emp.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>8129 Bullneck Rd. 21222   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Elias Hudson  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jessie Mix   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>220/05/7863   |  | 17. INFORMANT (Niece) ADDRESS<br>Deloris Sowells 52 Maple Dale Ave<br>Glen Burnie 21061  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4280 Cardiorespiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>S.E. VALONE  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S.E. VALONE   |  |  |  |   |  | 22e. ADDRESS<br>BCH  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 5, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Prk   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dean P. Charlton<br>Singleton Funeral Home Glen Burnie, Md   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RETURN TO THE REGISTRAR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13397  
REG. NO.

|  |         |  |        |   |                            |   |                  |   |                        |      |   |
|--|---------|--|--------|---|----------------------------|---|------------------|---|------------------------|------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE | LAST  | 2a. DATE KNOWN<br>OF DEATH |   | ESTI-<br>MATED   | MONTH   | DAY                    | YEAR | 2b. HOUR  |
| William A. Smith Sr.   |         |  |        |   | XX                         |   |                  | 5   | 11                     | 1984 | M   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS)   | IF UNDER 1 YR.             |   | IF UNDER 24 HRS. |   | 2c. DATE<br>PRONOUNCED |      | 2d. HOUR  |
| Male   | Black   | June 1, 1910   |        | 73 YRS.   | MONTHS                     |   | DAYS             |   | 5 13 1984              |      | 10:16 A. M.                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                  |   |                        |      |   |
| Georgia  |         | U. S. A.   |        |   |                            | Baltimore City MD.  |                  |   |                        |      |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |                            | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |                  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |                        |      |   |
| Baltimore  |         | 1600 Mt. Royal Terrace, Apt.#1306  |        |   |                            | Railroad Employee   |                  | B & O Railroad  |                        |      |   |
| 13a. STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 13e. STREET ADDRESS   |                        |      |   |
| Maryland   |         |  |        | Baltimore   |                            |   |                  | 1600 W. Mount Royal Ave. Apt. 1306 Balto. Md. 21217                                 |                        |      |   |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |        |   |                            |   |                  |   |                        |      |   |
| Eugene   |         | Ethel  |        |   |                            |   |                  |   |                        |      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT ADDRESS   |                            |   |                  |   |                        |      |   |
| No.  |         | 705-09-9745  |        | William A. Smith Jr. Sacramento, Ca.  |                            |   |                  |   |                        |      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular<br>DUE TO, OR AS A CONSEQUENCE OF Disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>(c)  |         |  |        |   |                            |   |                  |   |                        |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |         |  |        |   |                            |   |                  |   |                        |      |   |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        |   |                            |   |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |      |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                            |   |                  |   |                        |      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |                  |   |                        |      |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |        |   |                            |   |                  |   |                        |      |   |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |        |   |                            |   |                  | DATE<br>SIGNED 5/14/84  |                        |      |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |        |   |                            |   |                  |   |                        |      |   |
| Ann M. Dixon, M.D.   |         | 111 Penn Street, Baltimore, MD 21201   |        |   |                            |   |                  |   |                        |      |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                            | 23d. LOCATION<br>CITY OR TOWN   |                  | COUNTY STATE  |                        |      |   |
| Burial   |         | 5/17/1984  |        | Arbutus Memorial Park   |                            | Baltimore, Maryland   |                  |   |                        |      |   |
| 24. FUNERAL DIRECTOR<br>NAME   |         | 25a. DATE REC'D. BY REGISTRAR  |        | 25b. REGISTRAR'S SIGNATURE  |                            |   |                  |   |                        |      |   |
| Nutter & Sons Funeral Home Inc.<br>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216  |         | MAY 17 1984  |        | Julia Davidson-Randall  |                            |   |                  |   |                        |      |   |

11-11-61

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARCIA M. SMOOT</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>5-16-84</b> |  |  | 2b. HOUR<br><b>3:40AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>                                    |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 10 86</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>(RETAIL)<br><b>Mont. Ward</b> |  |

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>1030 Shore Acres Rd</b>    |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |  |  | 13c. CITY OR TOWN<br><b>ARNOLD</b>                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MORRIS EUGENE</b>                          |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ODESSA HURLOCK KUBE</b>                     |  |  | 16. SOCIAL SECURITY NO.<br><b>226-10-2498</b>        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |  |  | 16b. SOCIAL SECURITY NO.<br><b>226-10-2498</b>  |  |  | 17. INFORMANT<br><b>EDWARD M. SMOOT (SAME AS 13)</b> |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1509</b> |  | IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>                       |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 minutes</b> |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                         |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the esophagus</b> |  |   |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                   |  |   |  |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  
**Generalized metastasis of esophageal carcinoma**

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING TO CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)<br><b>N/A</b> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> N/A <input type="checkbox"/><br>AT WORK <input type="checkbox"/> N/A <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>                               |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from **5/16/84** to **5/16** 19**84**, that (I) (we) last saw the deceased alive on **5/16** 19**84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.

|  |  |                     |  |   |  |                                    |  |
|--|--|---------------------|--|---|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>Allen C. Jackson MD</b>                           |  | DEGREE<br><b>MD</b> |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/16/84</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALLEN C. JACKSON, M.D.</b> |  |                     |  | 22e. ADDRESS<br><b>3001 S. Annapolis St., Balt., Md.</b>  |  |                                    |  |

|   |  |                                  |  |   |  |  |  |
|---|--|----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>MAY 18, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CROWNVILLE VETERANS CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CROWNVILLE ANNE ARUNDEL MD.</b> |  |
|---|--|----------------------------------|--|---|--|--|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT S. BARRANCO</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>na Davidson-Randall</b> |  |
|---|--|---|--|--|--|

1

10-10-10

(Scribbled text)

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W/A



Copyrighted material of copyright violation

Copyrighted material of copyright violation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 3 3 9 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                                      |   |
|--|--|---|--|---|--------------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAULINE A. SMUTNIAK</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-6-84</b> |   | 2b. HOUR<br>MIN.<br><b>9:00 A.M.</b> |   |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT-23, 1899</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2675 ELLWOOD AVE.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW STEFAN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2675 ELLWOOD AVE 21224</b>   |                                      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-07-7567</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>RAYMOND SMUTNIAK 212 DOWCASTER RD 21085</b>  |                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |   |  |   |                                      |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1977</b> , 19 <b>5/</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |                                      |   |
| 22b. SIGNATURE<br><b>Morton C. Orman</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                      | 22c. DATE SIGNED<br><b>5-7-84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORTON C. ORMAN</b>  |  | 22e. ADDRESS<br><b>2936 E. BALTO ST BALTO 21224</b>   |  |   |                                      |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-9-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY CEM.</b>   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CO. MD.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>THOMAS J. SKARDA</b>  |  | ADDRESS<br><b>2829 HUDSON ST.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |

BP



The following is a list of the  
 names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January 1880 at the  
 residence of Mr. J. H. Smith  
 in the town of  
 New York.  
 The names of the persons  
 who were present are as  
 follows:

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 13400

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                                   |  |  |
|---|--|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Barbara A. Sneed</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 7 84</i> |   | 2b. HOUR<br>MIN<br><i>10:05 P</i> |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7 31 95</i>  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>88</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY, MD.</i> |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>PIMLICO MANOR NURSING HOME</i> |  |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |                                   | 13d. STREET ADDRESS<br><i>3504 Berwyn Avenue 21207</i>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Jacob Stratton</i>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lethelder Bailey</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>Unknown</i>  |                                   |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>212-22-2934A</i>                                     |  | 17. INFORMANT<br>ADDRESS<br><i>Mary Barbour 3504 Berwyn Avenue</i>   |  |   |                                   |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i><br><i>4360</i><br>DUE TO, OR AS A CONSEQUENCE OF,<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>years</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>months</i> |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
*hypertension - m.c.*

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><i>May 7 1984</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 7 1984</i> to <i>May 7 1984</i> , that (I) (we) last saw the deceased alive on <i>May 7 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>David J. Miller M.D.</i>   |  | DEGREE<br><i>M.D.</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>5-7-84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>David J. Miller M.D.</i>  |  | 22e. ADDRESS<br><i>10219 S. Delfield St. Baltimore, MD 21117</i>       |  |  |  |  |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i> |  | 23b. DATE<br><i>5/11/84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Pk.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Arbutus, Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H Inc.</i>    |  |                             |  | ADDRESS<br><i>1101 E North Avenue</i>                         |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 8 1984</i>                |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |

OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301-1000

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APR 8 1994



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 13401  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 5 11 84  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUNICE L. SNOWDEN  |  |   |  | 2b. HOUR 5:00 P   |  |   |  |
| 3. SEX Female   |  | 4. RACE Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR 10 20 09  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.  |  |
| 10. CITY OR TOWN OF DEATH Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2352 Eutaw Place |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STREET ADDRESS 2352 Eutaw Place 21217  |  |   |  |
| 13a. STATE Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Balto.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Lipscomb   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Swift  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |   |  |
| 16b. SOCIAL SECURITY NO. 8  |  | 17. INFORMANT ADDRESS 7909 Mandan Rd. Mr. Donald Smith Greenbelt, Md. 20770   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Adult Onset Diabetes Mellitus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes<br>10 years<br>15 years |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hypertension</u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>December 6, 1978</u> to <u>April 11, 1984</u> that (I/we) last saw the deceased alive on <u>April 4, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>Lawrence E Klein M.D.</u>   |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence E Klein M.D.</u>  |  |   |  | 22e. ADDRESS <u>Harvey 502 Johns Hopkin Hospital</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 5/16/84   |  | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md   |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm C March F/H Inc.</u>  |  |   |  | ADDRESS <u>1101 E North Ave. Balto., Md.</u>  |  | 25a. DATE REC'D. BY REGISTRAR 16 1984   |  |

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CONFIDENTIAL

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BY [illegible] AT [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 0 2

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: FRANK J. LAST: SOBCTZYNSKI  |  |   | 2a. DATE OF DEATH<br>MONTH: MAY DAY: 15 YEAR: 1984   |  | 2b. HOUR<br>9:20 AM                          |
| 3. SEX<br>MALE  | 4. RACE<br>CAUC.   | 5. DATE OF BIRTH<br>MONTH: 10 DAY: 8 YEAR: 1992   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>87 YRS.  | IF UNDER 1 YEAR<br>MONTHS: DAYS: HOURS: MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City X MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>City   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John L. Deaton Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE: MARYLAND 13b. COUNTY: — 13c. CITY OR TOWN: BALTIMORE   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST: UNKNOWN MIDDLE: LAST: —   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST: UNKNOWN MIDDLE: LAST: —   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>216-01-2486   | 17. INFORMANT<br>ADDRESS: Dorothy Kocyan 5497 MOORE'S RUN DR.  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) —<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) —<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>sepsis, pneumonia, UTI, CVA, decubitus ulcers</u>  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>—   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—   |  |  |  |
| 21d. INJURY OCCURRED <input checked="" type="checkbox"/><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—  | 21f. LOCATION<br>STREET: — CITY OR TOWN: — COUNTY: — STATE: —   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 29</u> , 19 <u>83</u> , to <u>May 15</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>8:00 AM May 15 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Weinreich MD</u>   |  | DEGREE  | 22c. DATE SIGNED<br>5/15/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WEINREICH MD   |  | 22e. ADDRESS<br>J.L. DEATON MED. CTR., 611 S. CHAS ST., BALT  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>5/19/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cem  | 23d. LOCATION<br>CITY OR TOWN: BALTO COUNTY: MD STATE: —   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME: KACZOROWSKI FUNERAL HOME ADDRESS: 2535 FLETCHER ST.   |  | 25a. DATE REC'D. BY REGISTRAR: MAY 17 1984 25b. REGISTRAR'S SIGNATURE: John Davidson-Monroe   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into several paragraphs or sections, with some lines starting with capital letters. The handwriting is cursive and somewhat slanted. The page is lined, and the text is written in dark ink. There are some dark spots and smudges on the page, particularly on the right side.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item #16b. G-592, 6/1/84 by R. G. J.

FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13403

|   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |          |  |
|---|--|---------|-------------------|---|--|-------------------------|--|--|----------------|------------------|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST |   |  | 2a. DATE KNOWN OF DEATH |  |  | MONTH DAY YEAR |                  |  | 2b. HOUR  |  |          |  |
| MARTHA Anne Ryan  |  |         | SOLHEIM           |   |  | DATE ESTIMATED          |  |  | 5 21 1984      |                  |  | M   |  |          |  |
| 3. SEX  |  | 4. RACE |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.   |                | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR |  |
| F   |  | W       |                   | 6/17/35   |  | 48 YRS.                 |  | MONTHS DAYS  |                | HOURS MIN.       |  | 5 21 1984   |  | 7:24 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                         |  | 8. MARRIED   |                |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |  |
| VA  |  |         |                   | USA   |  |                         |  | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                  |  | Baltimore City MD.  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| Baltimore   |  |         |                   | 4757 Homesdale Ave.   |  |                         |  | Journalist-Self-Employed   |                |                  |  |   |  |          |  |
| 13a. STATE  |  |         |                   | 13b. COUNTY   |  |                         |  | 13c. CITY OR TOWN  |                |                  |  | 13d. INSIDE CITY LIMITS?  |  |          |  |
| MD  |  |         |                   |   |  |                         |  | Balto.   |                |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 14. FATHER'S NAME   |  |         |                   | 15. MOTHER'S MAIDEN NAME                                    |  |                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                |                  |  | 16b. SOCIAL SECURITY NO.  |  |          |  |
| Richard H. Ryan   |  |         |                   | Mary Mann   |  |                         |  | No   |                |                  |  | 230-38-9719   |  |          |  |
| 17. INFORMANT   |  |         |                   | ADDRESS   |  |                         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |          |  |
| J.T. Morris Funeral Home, VA  |  |         |                   |   |  |                         |  | PART I DEATH WAS CAUSED BY:  |                |                  |  |   |  |          |  |
|   |  |         |                   |   |  |                         |  | IMMEDIATE CAUSE (a) Gunshot wound of head (handgun)  |                |                  |  |   |  |          |  |
|   |  |         |                   |   |  |                         |  | DUE TO, OR AS A CONSEQUENCE OF   |                |                  |  |   |  |          |  |
|   |  |         |                   |   |  |                         |  | (b)  |                |                  |  |   |  |          |  |
|   |  |         |                   |   |  |                         |  | DUE TO, OR AS A CONSEQUENCE OF   |                |                  |  |   |  |          |  |
|   |  |         |                   |   |  |                         |  | (c)  |                |                  |  |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                         |  |  |                |                  |  | 20. AUTOPSY?  |  |          |  |
|   |  |         |                   |   |  |                         |  |  |                |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |                   | 21b. TIME OF INJURY   |  |                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                |                  |  |   |  |          |  |
|   |  |         |                   | ? P.M. 5-21-1984  |  |                         |  | Self-inflicted.  |                |                  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                         |  | 21f. LOCATION  |                |                  |  |   |  |          |  |
|   |  |         |                   | home  |  |                         |  | 4757 Homesdale Ave., Balto. City Md.   |                |                  |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |          |  |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                              |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |          |  |
| ACTUAL SIGNATURE  |  |         |                   | TITLE (SPECIFY)   |  |                         |  | DATE SIGNED  |                |                  |  |   |  |          |  |
| Ann M. Dixon, M.D.  |  |         |                   | M.D. Assistant MEDICAL EXAMINER                             |  |                         |  | 5-22-84  |                |                  |  |   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |                   | ADDRESS   |  |                         |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                |                  |  | 23b. DATE   |  |          |  |
| Ann M. Dixon, M.D.  |  |         |                   | 111 Penn St., Balto., Md. 21201                             |  |                         |  | Removal-Burial   |                |                  |  | 5/24/84   |  |          |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |                   | 25a. DATE REC'D. BY REGISTRAR                               |  |                         |  | 25b. REGISTRAR'S SIGNATURE   |                |                  |  |   |  |          |  |
| Henry W. Jenkins & Sons Co.   |  |         |                   | MAY 25 1984   |  |                         |  | na Davidson-Randall  |                |                  |  |   |  |          |  |
| 4905 York Road Balto., MD 21212   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |          |  |

1990-1991

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

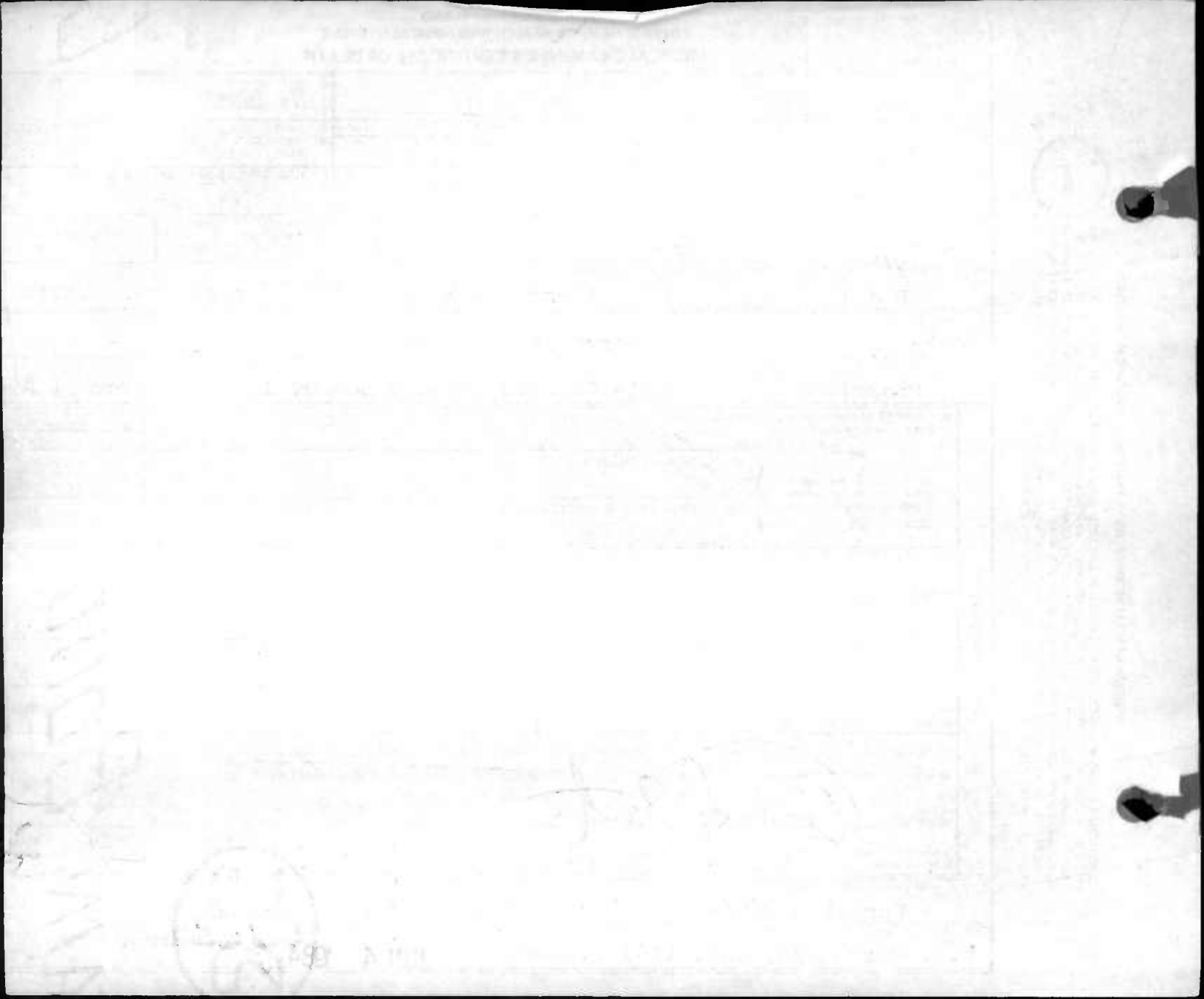
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |              |   |  |   |   |
|--|--------------|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rev. JOHN SOMERVILLE  |              |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>5-31-84 |   | 2b. HOUR<br>19  |
| 3. SEX<br>M  | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 5 15                | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>69 YRS.      | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-31-83 19                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NC  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |              | 10. CITY OR TOWN OF DEATH<br>Baltimore                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1618 Normal Avenue                            |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |              | 12b. KIND OF BUSINESS OR INDUSTRY                           |  | 13a. STATE<br>MD  |   |
| 13b. COUNTY  |              | 13c. CITY OR TOWN<br>Baltimore                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 13e. STREET ADDRESS<br>1618 Normal Ave. 21213  |              | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Somerville   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |              | 16b. SOCIAL SECURITY NO.<br>214-03-0454                     |  | 17. INFORMANT<br>ADDRESS<br>Pamela Somerville 1618 Normal Ave   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) Carcinoma of colon<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |              |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |              |   |  |   |   |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19  |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |              |   |  |   |   |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.  |              | TITLE (SPECIFY)<br>Deputy Chief                             |  | DATE 6-1-84<br>SIGNED   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |              | ADDRESS<br>111 Penn Street                                  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |              | 23b. DATE<br>6/4/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park  |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Randallstown  |              | COUNTY<br>MD  |  | STATE   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.C. March F/H, Inc. 1101 E. North   |              | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 4 1984   |   |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |              |   |  |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |                                  |  |  |
|---|--|---|--|---|---|--|----------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |   | 1 3 4 0 5  |                                  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE</b> <b>SORVALIS</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>05</b> DAY <b>05</b> YEAR <b>84</b>                               |  | 2b. HOUR <b>12</b> MIN <b>22</b> |  |  |
| 3. SEX<br><b>Male M</b>   |  | 4. RACE<br><b>White C</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>15</b> YEAR <b>97</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                    |                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hosp</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pittsburgh Steel</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>9301 Plogstone Dr. 21234</b>                    |                                  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Panagiotis</b> MIDDLE <b>Sorvalis</b> LAST <b>Sorvalis</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Triandaphilo</b> MIDDLE <b>Zoulota</b> LAST <b>Zoulota</b> |  |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>272 03 6827</b>   |  | 17. INFORMANT ADDRESS<br><b>Maria Sorvalis same as 13 e</b>   |   |  |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory distress</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Prostatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1420</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1420</b>  |  |   |  |   |   |  |                                  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |                                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                                  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/21/84</b> to <b>5/25/84</b> , that (1) (we) last saw the deceased alive on <b>5/25/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |                                  |  |  |
| 22b. SIGNATURE<br><b>Meenakshi Patel</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   |  |                                  | 22c. DATE SIGNED<br><b>5/25/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MEENAKSHI PATEL</b>   |  | 22e. ADDRESS<br><b>SINAI Hosp.</b>  |  |   |   |  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-28-1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orthodox</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |                                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Felia Davidson-Randell</b>                          |                                  |  |  |

MEDICAL CERTIFICATION

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

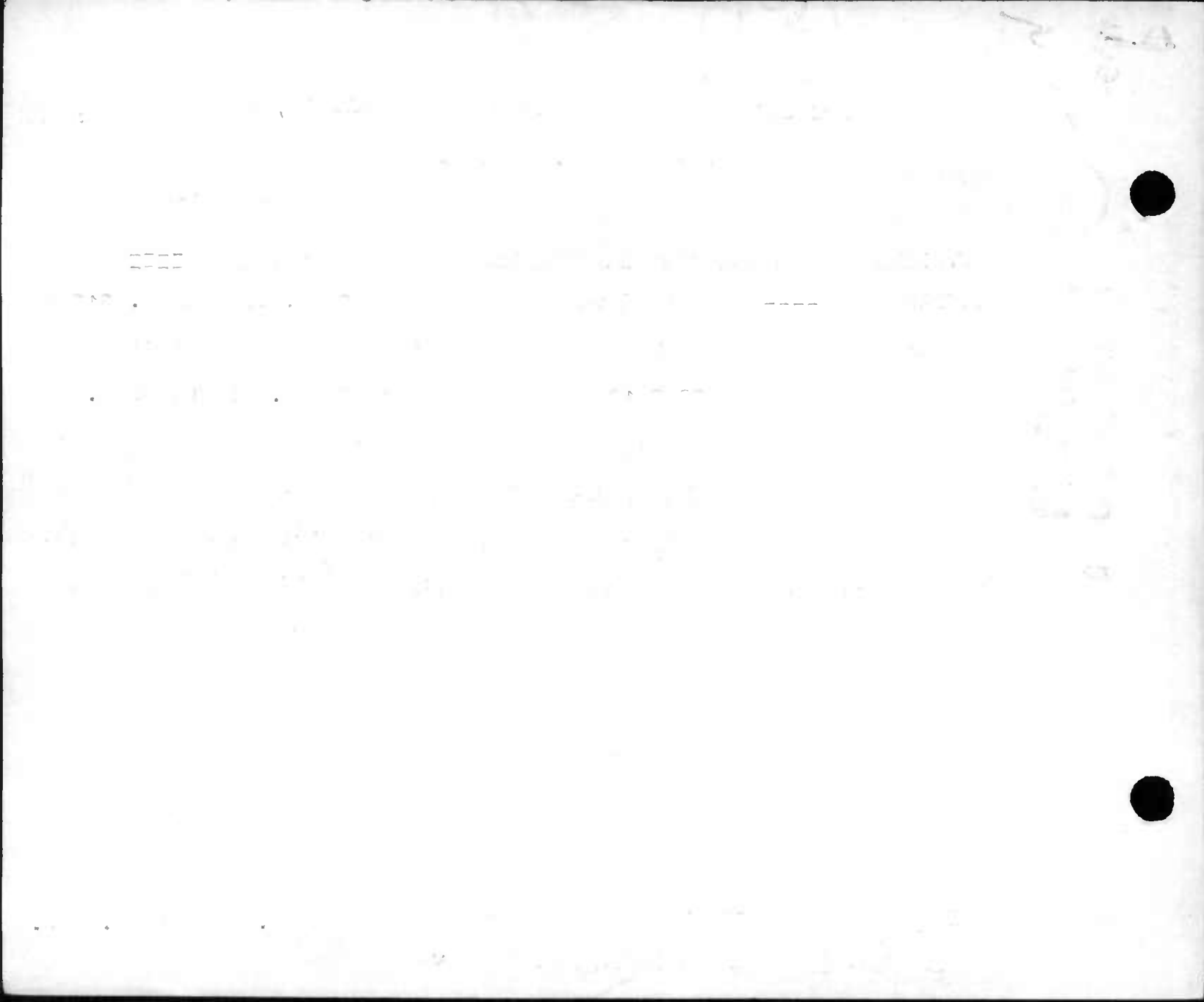
|   |  |  |  |   |   |  |   |   |                                       |  |
|---|--|--|--|---|---|--|---|---|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRIETTA SPEARS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 25, 1984</b>                           |   |   | 2b. HOUR<br><b>10:08 PM</b>  |   |   |                                       |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 09 27</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                       |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |   |   |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |                                       |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>----</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARVE THOMPSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BERTHA BEALL</b>                 |   |   | 16. ADDRESS<br><b>DANNY SPEARS 509 S. LINWOOD AVE.</b>                                       |   |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>227281379</b>   |   | 17. INFORMANT<br><b>DANNY SPEARS</b>                          |  |   |   | ADDRESS<br><b>509 S. LINWOOD AVE.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ANTERIOR MYOCARDIAL INFARCT</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MULTIPLE THROMBOTIC EVENTS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SQUAMOUS CELL LUNG CANCER</b>                                    |  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 hrs</b><br><b>6 month</b><br><b>1 year</b>                            |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE, DIABETES</b>  |  |  |  |   |   |  |   |   |                                       |  |
| 19a. DATE OF OPERATION<br><b>---</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>---</b> |   |   |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b> |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>---</b>                              |   |   |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 25</b> 19 <b>84</b> to <b>MAY 25</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>MAY 25</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did (I) did not view the body after death. |  |  |  |   |   |  |   |   |                                       |  |
| 22b. SIGNATURE<br><b>Ralph Altman M.</b>  |  |  |  |   |   | DEGREE<br><b>---</b>   |   | 22c. DATE SIGNED<br><b>25 MAY</b>   |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RALPH ALTMAN</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL, BALTIMORE</b>                                     |   |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>5/29/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b>                          |   |                                       |  |
| 24. FUNERAL DIRECTOR<br><b>John</b>   |  |  |  |   |   | 25. DATE REC'D BY REGISTRAR<br><b>MAY 29 1984</b>  |   |   |                                       |  |
| ADDRESS<br><b>1211 Chesapeake Ave.</b>  |  |  |  |   |   | REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |   |                                       |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove your signature and the signature of the physician and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other cause of death, a medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |  |  |   |
|--|-------------------------|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRENE N. SPENCER</b>                    |                         | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>19</b> YEAR <b>1984</b>   |  | 2b. HOUR<br><b>9:15am</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br><b>JULY 28 1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>WEST VIRGINIA</b>                      |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, MD.</b>                       |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>102 N. PACA ST.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b> |
| 13a. STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>102 N. PACA ST. 21201</b>                      |
| 14. FATHER'S NAME<br>FIRST <b>UNKNOWN</b> LAST                                 |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNKNOWN</b> LAST  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> |                         | 16b. SOCIAL SECURITY NO.<br><b>219-10-5181</b>   |  | 17. INFORMANT<br>ADDRESS <b>21201 CENTURY HOME, INC. 102 N. PACA ST.</b>            |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>5070</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST.</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>45 min</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aspiration Pneumonia</b>   |  | <b>Unknown</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|  |  |                  |
|--|--|------------------|
| 22a. SIGNATURE<br><b>McCauley</b>                        | DEGREE   | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>McCauley</b> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                  |
| 22e. ADDRESS<br><b>22 S. GAYNE ST.</b>                   |  |                  |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  | 23b. DATE<br><b>05/23/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW MEMORIAL</b> | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE |
| 24. FUNERAL DIRECTOR <b>MARSHALL W. JONES, JR.</b><br>NAME ADDRESS <b>4101 EDMONDSON AVE./BALTO., Md. 21229</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>            | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson Jones</i>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |  |   |  |
|--|-------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR   |                         | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MORTON SPENCER</b>  |                         | 5/15/84  |  | 1245 P M  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 5 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b>   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Trackman</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Patapsco Back River RR</b>   |  | 13. STREET ADDRESS<br><b>4009 Forest Park Ave. Baltimore, Maryland 21207</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eddie Spencer</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta Morton</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>705-10-9484</b>   |                         | 17. INFORMANT<br><b>Iviner Spencer Baltimore, Maryland 21207</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gram Negative septicemia -</b><br><b>5996</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>obstructive uropathy.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Renal failure - Cardiac Arrhythmias</b>  |                         |  |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> , 19 <b>84</b> , to <b>5/15</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                         |  |  |   |  |
| 22b. SIGNATURE<br><b>Bich T Duong</b>  |                         | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>5/15/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T DUONG</b>   |                         | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>5/19/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |                         | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>                          |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 17 1984</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |   |  |



|           |                      |   |   |      |  |
|-----------|----------------------|---|---|------|--|
| White     | Black                | 3 | 2 | 1206 | 78   |
| Virginia  | U. S. A.             | X |   |      | Baltimore City   |
| Baltimore | Interracial Hospital |   |   |      | Townman<br>4000 Forest Park Ave.<br>Baltimore, Maryland 21207      |
| Maryland  | Baltimore            | X |   |      | Baltimore, Maryland 21207  |
| Eddie     | Spencer              |   |   |      | Herrington<br>4000 Forest Park Avenue<br>Baltimore, Maryland 21207 |
| No.       | 005-10-3484          |   |   |      | 171st Spencer<br>Baltimore, Maryland 21207                         |

*[Faint, illegible handwritten notes and markings covering the middle section of the page.]*

2201 Cypress Falls Pkwy. Baltimore, Md. 21218  
 Letter to Jones Funeral Home Inc.  
 2/19/1964 Cedar Hill Cemetery  
 Baltimore, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO. 84 13409                |  |  |  |  |
|--|--|--|--|---|----------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR |  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>CARRIE ONEDA SPIELMAN  |  |  |  |   | 5/9/84                           |  |  |  |  |
| 3. SEX F   |  | 4. RACE W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>09 12 18   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  | 7b. HOUR 9:20 AM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Maryland |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RESTAURANT   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>COOK KEYMAR, MD.  |  |  |  |
| 13a. STATE MARYLAND  |  | 13b. COUNTY CARROLL  |  | 13c. CITY OR TOWN KEYMAR  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS ZIP CODE<br>12236 DETOUR RD PO BOX 12 KEYMAR, MD 21757 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>NORMAN  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>NETTIE STULTZ  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |                                  | 16b. SOCIAL SECURITY NO.<br>220-07-9410  |  | 17. INFORMANT ADDRESS<br>RONALD SPEILMAN - KEYMAR MD 21757                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>disseminated cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>unknown primary tumor</u>  |  |  |  |   |                                  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 weeks                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (11a)<br><u>Thrombocytopenia, Renal Failure, CVA, DVT</u>  |  |  |  |   |                                  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                                  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> , 19 <u>84</u> , to <u>5/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                  |  |  |  |  |
| 22b. SIGNATURE<br>Edward B. Bolgiano   |  |  |  | DEGREE<br>MD  |                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/9/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD B. BOLGIANO  |  |  |  | 22e. ADDRESS<br>S. Greene St. BALTIMORE 21201   |                                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MAY 12-1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HAUGH'S MT ZION   |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>LADIESBURG FREDERICK MD   |  |  |  |
| 24. FUNERAL DIRECTOR<br>D.D. Hartzler Union Bridge Md  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984  |                                  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 704 13410   |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>OTIS STALEY, SR.   |  |   |  | 2a. DATE OF DEATH (MONTH DAY YEAR)<br>MAY 17 1984   |  | 2b. HOUR<br>8-10 P.M.  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>MAY 14 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66  |  | 7. IF UNDER 1 YEAR (MONTHS DAYS) IF UNDER 24 HRS (HOURS MIN.)                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH. STEEL   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>O. HAMPTON  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANN STALEY  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>718-12-9843   |  | 17. INFORMANT ADDRESS<br>HELEN STALEY/1638 E. 25th ST. 21213  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Terminal pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>84</u> , to <u>5-17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Rifat S. Ashai   |  |   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br>5-17-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RIFFAT S. ASHAI M.D.  |  |   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>05/21/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR<br>MARSHALL W. JONES, JR.<br>NAME ADDRESS<br>4101 EDMONDSON AVE./BALTO., Md. 21229  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984  |  |  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>F. Davidson-Randall   |  |  |  |  |  |

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• *Leaves* – 2 to 3 pairs of leaflets, 1 to 2 inches long, 1/2 to 1 inch wide, pinnate, serrated, dark green above, light green below.

• 2012 •

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |  |  |  |  | REG. NO. 13411  |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bryan Keith Stansbury</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>5 27 1984</b>                           |  | 2b. HOUR <b>M</b>  |  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec. 30 1962</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>21</b>  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 27 1984</b>                                  |  | 7d. HOUR <b>1:20 p M</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>943 Horners Lane 21205</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nursing Assistant</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing Home</b>                               |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY <b>-</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET ADDRESS <b>1118 Quantril Way 21205</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Emerson E. Stansbury</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Elsie Stone</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>166 60 8678</b>  |  | 17. INFORMANT ADDRESS <b>1024 Lerew Way Emerson E. Stansbury Balto., Md. 21205</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9550</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest (handgun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____   |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR <b>1:10 p M 5 27 19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self inflicted</b>  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>943 Horners Lane, Baltimore Md.</b>   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Gregory R. Kauffman</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>   |  |  |  | DATE SIGNED <b>5/28/84</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |                      |  | 23b. DATE <b>5/31/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>                         |  |   |  |
| 24. FUNERAL DIRECTOR <b>Brodzinski Funeral Home</b>  |  |                      |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 29 1984</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>                                     |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |                           |   |  |
|---|--|---|--|--|---------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rudolph Steen</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-16-84</b> |  | 2b. HOUR<br><b>230A M</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 25 13</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery Store</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>13a. STATE A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           | 13e. STREET ADDRESS / ZIP CODE<br><b>7014 Forest Smallwood Rd. 21226</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Toller Steen</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sine Neilson</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b><br><b>WW II</b>   |                           | 16b. SOCIAL SECURITY NO.<br><b>215-01-2406</b>  |  |
| 17. INFORMANT<br><b>Mildred A. Steen</b>  |  | ADDRESS<br><b>Same as 13e</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Pulmonary arrest</b><br><b>4273</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHF and stroke organ failure</b> |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |                           |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                           |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                           |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/19</b> 19 <b>84</b> , to <b>5/16</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/16/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                           |   |  |
| 22b. SIGNATURE<br><b>Freeman - Penocraft</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                           | 22c. DATE SIGNED<br><b>5/16/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Freeman - Penocraft</b>   |  | 22e. ADDRESS<br><b>80 Baltimore Ave - Hagerstown</b>  |  |  |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/19/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial Ph</b>  |                           | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonca 4001 Ritchie Hwy Balto Md</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1984</b>  |                           |   |  |



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |   |  |  |   |   |   |  |  |  |
|---|--|---|---|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>IDA SARAH STEIN</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 / 19 / 84</b>              |  | 2b. HOUR<br><b>4:30 A</b> M  |   |   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>07 10 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>79</b>                                 |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shahi Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESLADY</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LADIES APPAREL</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>MARYLAND BALTIMORE BALTIMORE</b>  |  |   |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>6600 COPPER RIDGE DR., APT. 101 #21209</b> |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HARRY STEIN</b>   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>REBECCA PER</b>   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>216-07-6152</b>  |   | 17. INFORMANT MRS. ELAINE PER<br><b>6600 COPPER RIDGE DR., APT. 101 #21209</b>   |  |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/19</b> , 19 <b>84</b> , to <b>5/19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |   |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Elton David Reister</b>  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elton David Reister</b>   |  |   |   |  | 22e. ADDRESS<br><b>Shahi Hosp</b>  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>MAY 20, 1984</b>                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH HAMEDROSH HAGODOL ROSEDALE</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>                     |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |  |   |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   |   |   |   |  | 26. REGISTRAR'S SIGNATURE<br><b>J. H. Davidson-Randall</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Walter Steiner</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 28 84</i>                  |   |  | 2b. HOUR<br><i>7A-M</i>  |  |  |  |
| 3. SEX<br><i>male</i>   |  | 4. RACE<br><i>caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 17 1909</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>75</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD</i>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SO. Baltimore General Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>BOOKS UNDER</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>1</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>2614 Gehb Ave</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Steiner</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>IDA Hoyle</i>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>yes</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WEL II 215-05-2776</i>   |  | 17. INFORMANT<br><i>Kathy Steiner</i>   |  | ADDRESS<br><i>same as above</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>1629 Detonatic Snare cell carcinoma - lung</i><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Michael Schwartz MD</i>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>5-28-84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Michael Schwartz MD</i>   |  |  | 22e. ADDRESS<br><i>606 Hannovers Lane</i>                              |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br><i>BURIAL</i>   |  | 23b. DATE<br><i>5-1-84</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>LOUDON PK.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO MD</i>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>WEBER FUNERAL HOME</i>   |  |  | ADDRESS<br><i>5311 EDMONDSON</i>                                       |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 1 1984</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson-Rendall</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

male

conductor

MD

Baltimore City 20 - Baltimore General Hospital

MD

Baltimore

6014 Galt Ave

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

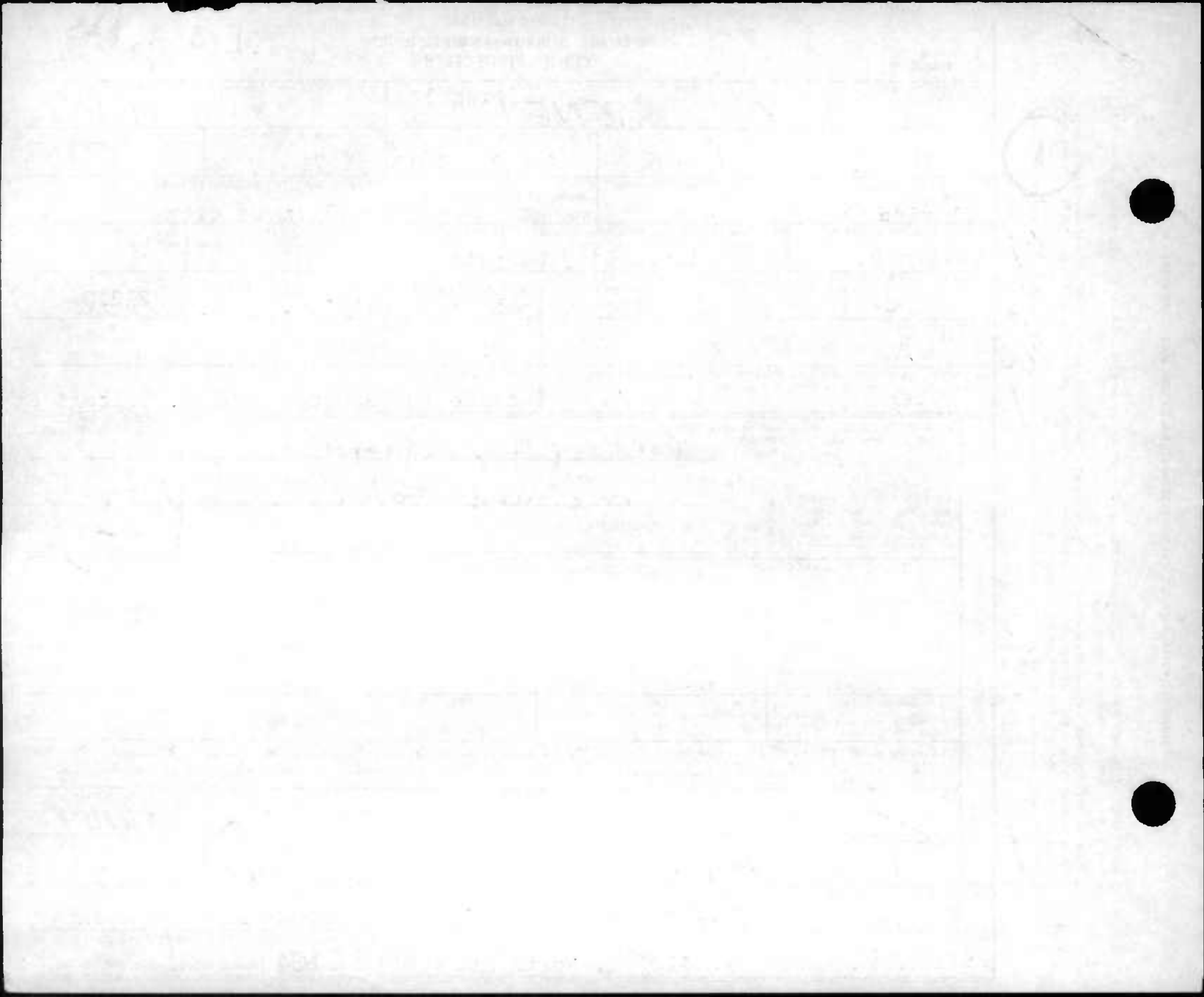
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                  |  |  |   |   |
|--|------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>J C STONE (STONE)   |                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 16 84          |   | 2b. HOUR<br>11:30 P.M.                          |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 29 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.   |                  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital   |                  |  |  |   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13b. COUNTY Balto 13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13d. STREET ADDRESS / ZIP CODE 1803 N. Washington St 21213   |                  |  |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>N/A  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>N/A |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT ADDRESS<br>Willie Lee Spencer 2307 N. Pulaski St  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary collapse</u><br>5850 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Renal Failure</u><br>10 years.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |                  |  |  |   |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/78</u> , 19 <u>84</u> , to <u>5/16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/16</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |                  |  |  |   |   |
| 22b. SIGNATURE<br>Ira Shapiro  |                  | DEGREE   |  | 22c. DATE SIGNED<br>5/17/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                  | 22e. ADDRESS<br>Baltimore City Hosp. M.  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>5/21/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md Veteran Cem  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville Md   |                  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>William C. March F/H 1101 E. North Ave   |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984   |                  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 1 3 4 1 6  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MCROTHY DOLLIE (M) STENNIS</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 / 9 / 84</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 3 32</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.   |  | 7a. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 7b. HOUR<br><b>5 P.M.</b>  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GENERAL HOSPITAL</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Wilson</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Eurice Pitts</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>                          |  |
| 17. INFORMANT ADDRESS<br><b>Myrtha Stennis 204 N. Bethel Court</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2501 SEPTICEMIA &amp; SHOCK</b><br>IMMEDIATE CAUSE (a)<br><b>2501 DUE TO, OR AS A CONSEQUENCE OF CARDIORESPIRATORY FAILURE</b><br>(b)<br><b>2501 DUE TO, OR AS A CONSEQUENCE OF DIABETIC ACIDOSIS</b><br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/8 19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/8 19 84</b> , to <b>5/9 19 84</b> , that (I) (we) last saw the deceased alive on <b>5/9 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (that) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>A.C. Chouvalit, M.D.</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>5/9/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.C. CHOUVALIT, M.D.</b>  |  | 22e. ADDRESS<br><b>NORTH CHARLES GEN. HOS.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/15/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |



Handwritten text, possibly a signature or initials, written vertically in the center-left area.



Handwritten text, possibly a signature or initials, written vertically below the circular stamp.

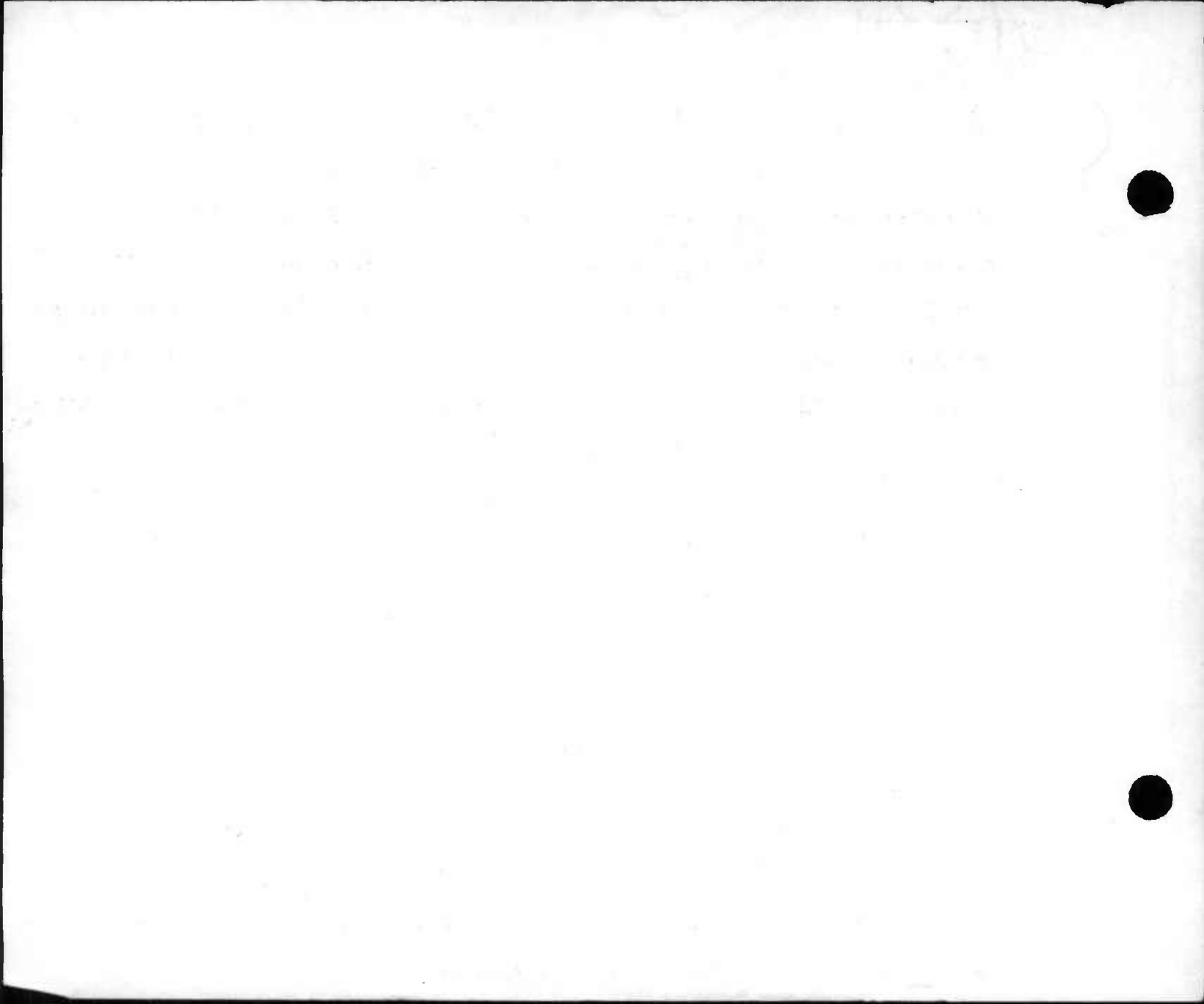
Vertical text, possibly a date or reference number, written in the lower center area.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| JAMES GAYLES STEVENS  |  |  | 5 19 84   |  |  | 1:00a M   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH              |  |  |
| MALE  | BLACK  | 8 9 28   | 55 YRS  |  |  | BALTIMORE, CITY MD.                               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |  |
| APPROMATAX, VA  | U.S.A.   |  | LABORER   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 13a. STREET ADDRESS / ZIP CODE   |   |  | 13b. INSIDE CITY LIMITS?   |   |  |  |
| BALTIMORE   | VAMC 3900 LOCH RAVEN BLVD 21218  | 1265 DECATER ST. CAMDEN, N.J.  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME                          |  |  |
| N.J.  |  | CAMDEN   | HUDSON EUGENE STEVENS   |  |  | MASSIE MARGARETT WATSON                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  | 16b. SOCIAL SECURITY NO.                                      |  |  | 17. INFORMANT                                     |  |  |
| YES II  |  |  | 226325808   |  |  | DIONNE CUMMINGS - 1265 DECATER ST. - CAMDEN, N.J. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4824 IMMEDIATE CAUSE (a) Cardiac arrest   |  |  |   |  |  |   |  | 1 hour                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |   |  | 1 hour                                       |
| (b) Metabolic Acidosis  |  |  |   |  |  |   |  | 1 hour                                       |
| (c) Staphylococcal pneumonia  |  |  |   |  |  |   |  | 1 week                                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |  |  |
| Diabetic Ketoacidosis   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |   |  |  |
|   |  | P.M. 19  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that X (this hospital) attended the deceased from MAY 10 19 84 to MAY 19 19 84 that X (we) last saw the deceased alive on MAY 19 19 84 and that in (b) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (not) view the body after death. |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE  |  |  |   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| KEVIN SCOTT FERENTE MD  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 5/21/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e. ADDRESS   |   |  |  |
| KEVIN SCOTT FERENTE MD  |  |  |   |  | 3900 LOCH RAVEN BLVD BALTO, MD 21218   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION                                     |  |  |
| BURIAL  |  | 5/30/84  |   | CHELTON HILLS CEM.   |  | 1701 E. WASHINGTON LANE PHIL., PA.                |  |  |
| 24. FUNERAL DIRECTOR  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                        |  |  |
| NAME ADDRESS  |  |  |   | MAY 23 1984  |  |   |  |  |
| WM. C. BROWN COMM. F/H  |  |  |   | 1206-1208 W. NORTH AVE   |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

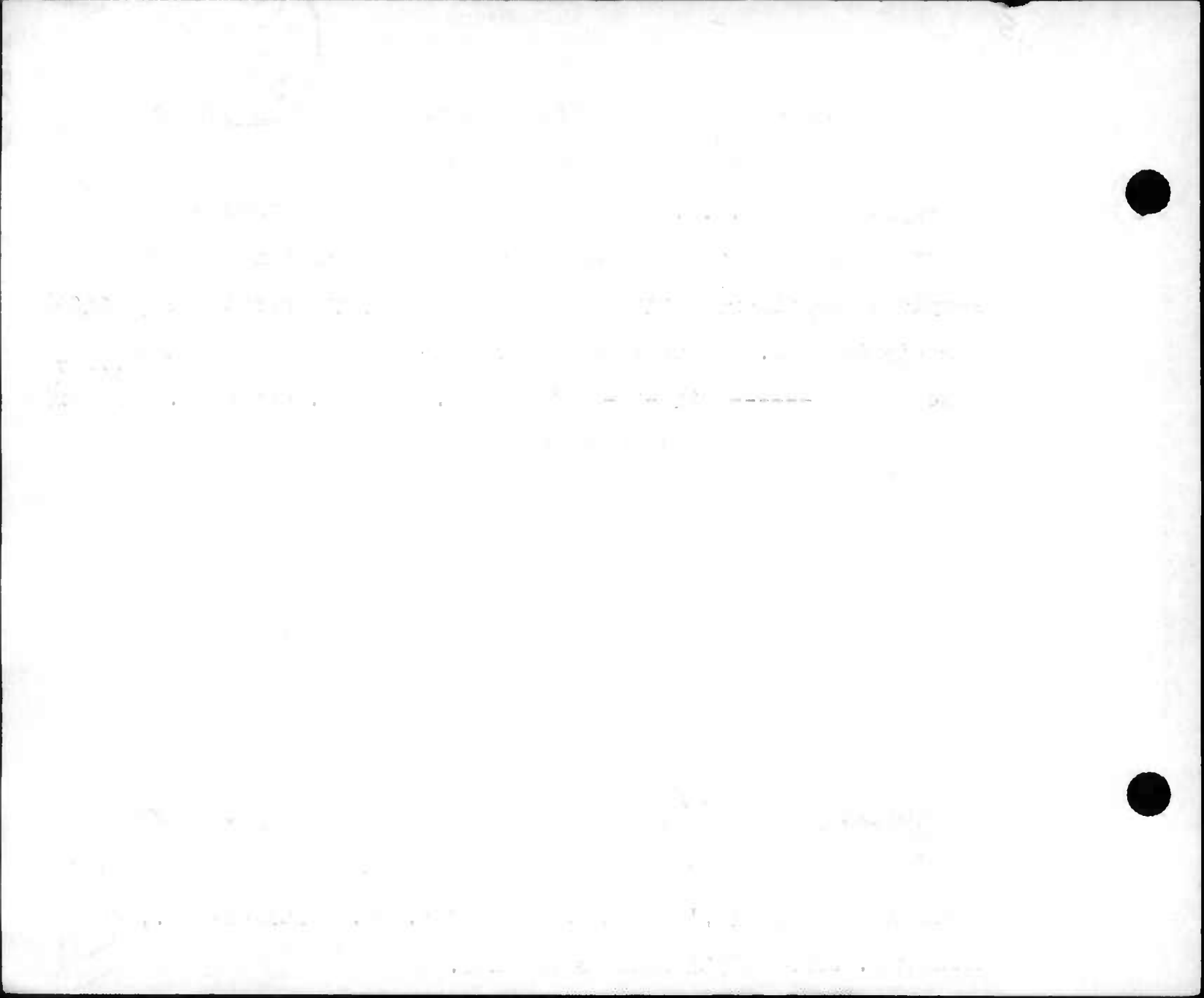
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH84 13418  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Blanche M. Stevenson  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/13/84                         |   |  | 2b. HOUR<br>2:00 P.M.  |   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 10 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hosp |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>21204                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin L. Stevenson  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise Addicks        |   |  | 16. STREET ADDRESS / ZIP CODE<br>1613 Mussula Road 21204   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>214-20-0763                                |   | 17. INFORMANT<br>David W. Mooney                               |  |   |  | ADDRESS<br>22301 E. Custis Ave. Alexandria VA      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Metastatic Lung Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>VA |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Mario Littman, MD  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>5/13/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mario Littman   |  |  |  |   |  | 22e. ADDRESS<br>5601 Loch Raven Blvd.  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>May 16, '84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gar. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., MD                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984   |   |  |  |  |
| ADDRESS<br>8521 Loch Raven Blvd.   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#12AB, Film G592 6/19/84 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 1 9

1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |   |   |  |
|---|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert J. Stevenson</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>12</b> YEAR <b>84</b>                        |   | 2b. HOUR<br><b>8:00 A.M.</b>   |   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>18</b> YEAR <b>14</b>  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>69</b> YRS.                        |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Md. Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Night Watchman Merchants</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>terminal</b>                      |   |   |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Samuel</b> MIDDLE <b>Stevenson</b> LAST <b>Stevenson</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EMMA</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b> |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>3/27/43 218-10-110</b>                                   |   | 17. INFORMANT<br><b>Luella R. Stevenson</b>                                    |   |   | ADDRESS<br><b>520 Mt. Holly St.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Altered Mental Status</b>  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>1 month</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diffuse Histocytic Lymphoma with Meningeal Involvement</b>   |  |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>84</b>                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 7</b> 19 <b>84</b> , to <b>April 12</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>April 12</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Duane T. Smoot MD</b>  |  |  | 22c. DATE SIGNED<br><b>5/12/84</b>  |   |  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Duane Smoot MD</b>  |  |
| 22e. ADDRESS<br><b>225 Green St Balto, Md. 21201</b>  |  |  |   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>5/17/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Garrett</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Quings Mills, Md.</b>                          |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>The Bailey General Home</b>  |  |  | ADDRESS<br><b>1348 N. Calhoun</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1984</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | 8 4 1 3 4 2 0   |  |
|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ANN GORMAN STEWART  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 28 84                                   |   | 2b. HOUR<br>7:40 P.M.  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 2, 1924  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>11 Charlclote Place |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>11 Charlclote Place 21218   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alan Bowen Gorman  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Stockmar  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-16-8137   |   | 17. INFORMANT ADDRESS<br>Mr. G.A. Stewart Jr. 11 Charlclote Pl. 21218         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> 19 <u>81</u> , to <u>May 27</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>May 27</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.           |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Doris M. Hahn</u>   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>5/28/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Doris M. Hahn</u>  |  | 22e. ADDRESS<br>5801 Loch Raven Blvd 21234  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 30, 1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Arlington   |  | COUNTY<br>Virginia  |   | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home  |  | ADDRESS<br>6500 York Road 21212   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 1 1984   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Davidson Handell</u>  |  |

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



|      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      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| 1917 | 1918 | 1919 | 1920 | 1921 | 1922 | 1923 | 1924 | 1925 | 1926 | 1927 | 1928 | 1929 | 1930 | 1931 | 1932 | 1933 | 1934 | 1935 | 1936 | 1937 | 1938 | 1939 | 1940 | 1941 | 1942 | 1943 | 1944 | 1945 | 1946 | 1947 | 1948 | 1949 | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2034 | 2035 | 2036 | 2037 | 2038 | 2039 | 2040 | 2041 | 2042 | 2043 | 2044 | 2045 | 2046 | 2047 | 2048 | 2049 | 2050 | 2051 | 2052 | 2053 | 2054 | 2055 | 2056 | 2057 | 2058 | 2059 | 2060 | 2061 | 2062 | 2063 | 2064 | 2065 | 2066 | 2067 | 2068 | 2069 | 2070 | 2071 | 2072 | 2073 | 2074 | 2075 | 2076 | 2077 | 2078 | 2079 | 2080 | 2081 | 2082 | 2083 | 2084 | 2085 | 2086 | 2087 | 2088 | 2089 | 2090 | 2091 | 2092 | 2093 | 2094 | 2095 | 2096 | 2097 | 2098 | 2099 | 2100 | 2101 | 2102 | 2103 | 2104 | 2105 | 2106 | 2107 | 2108 | 2109 | 2110 | 2111 | 2112 | 2113 | 2114 | 2115 | 2116 | 2117 | 2118 | 2119 | 2120 | 2121 | 2122 | 2123 | 2124 | 2125 | 2126 | 2127 | 2128 | 2129 | 2130 | 2131 | 2132 | 2133 | 2134 | 2135 | 2136 | 2137 | 2138 | 2139 | 2140 | 2141 | 2142 | 2143 | 2144 | 2145 | 2146 | 2147 | 2148 | 2149 | 2150 | 2151 | 2152 | 2153 | 2154 | 2155 | 2156 | 2157 | 2158 | 2159 | 2160 | 2161 | 2162 | 2163 | 2164 | 2165 | 2166 | 2167 | 2168 | 2169 | 2170 | 2171 | 2172 | 2173 | 2174 | 2175 | 2176 | 2177 | 2178 | 2179 | 2180 | 2181 | 2182 | 2183 | 2184 | 2185 | 2186 | 2187 | 2188 | 2189 | 2190 | 2191 | 2192 | 2193 | 2194 | 2195 | 2196 | 2197 | 2198 | 2199 | 2200 | 2201 | 2202 | 2203 | 2204 | 2205 | 2206 | 2207 | 2208 | 2209 | 2210 | 2211 | 2212 | 2213 | 2214 | 2215 | 2216 | 2217 | 2218 | 2219 | 2220 | 2221 | 2222 | 2223 | 2224 | 2225 | 2226 | 2227 | 2228 | 2229 | 2230 | 2231 | 2232 | 2233 | 2234 | 2235 | 2236 | 2237 | 2238 | 2239 | 2240 | 2241 | 2242 | 2243 | 2244 | 2245 | 2246 | 2247 | 2248 | 2249 | 2250 | 2251 | 2252 | 2253 | 2254 | 2255 | 2256 | 2257 | 2258 | 2259 | 2260 | 2261 | 2262 | 2263 | 2264 | 2265 | 2266 | 2267 | 2268 | 2269 | 2270 | 2271 | 2272 | 2273 | 2274 | 2275 | 2276 | 2277 | 2278 | 2279 | 2280 | 2281 | 2282 | 2283 | 2284 | 2285 | 2286 | 2287 | 2288 | 2289 | 2290 | 2291 | 2292 | 2293 | 2294 | 2295 | 2296 | 2297 | 2298 | 2299 | 2300 | 2301 | 2302 | 2303 | 2304 | 2305 | 2306 | 2307 | 2308 | 2309 | 2310 | 2311 | 2312 | 2313 | 2314 | 2315 | 2316 | 2317 | 2318 | 2319 | 2320 | 2321 | 2322 | 2323 | 2324 | 2325 | 2326 | 2327 | 2328 | 2329 | 2330 | 2331 | 2332 | 2333 | 2334 | 2335 | 2336 | 2337 | 2338 | 2339 | 2340 | 2341 | 2342 | 2343 | 2344 | 2345 | 2346 | 2347 | 2348 | 2349 | 2350 | 2351 | 2352 | 2353 | 2354 | 2355 | 2356 | 2357 | 2358 | 2359 | 2360 | 2361 | 2362 | 2363 | 2364 | 2365 | 2366 | 2367 | 2368 | 2369 | 2370 | 2371 | 2372 | 2373 | 2374 | 2375 | 2376 | 2377 | 2378 | 2379 | 2380 | 2381 | 2382 | 2383 | 2384 | 2385 | 2386 | 2387 | 2388 | 2389 | 2390 | 2391 | 2392 | 2393 | 2394 | 2395 | 2396 | 2397 | 2398 | 2399 | 2400 | 2401 | 2402 | 2403 | 2404 | 2405 | 2406 | 2407 | 2408 | 2409 | 2410 | 2411 | 2412 | 2413 | 2414 | 2415 | 2416 | 2417 | 2418 | 2419 | 2420 | 2421 | 2422 | 2423 | 2424 | 2425 | 2426 | 2427 | 2428 | 2429 | 2430 | 2431 | 2432 | 2433 | 2434 | 2435 | 2436 | 2437 | 2438 | 2439 | 2440 | 2441 | 2442 | 2443 | 2444 | 2445 | 2446 | 2447 | 2448 | 2449 | 2450 | 2451 | 2452 | 2453 | 2454 | 2455 | 2456 | 2457 | 2458 | 2459 | 2460 | 2461 | 2462 | 2463 | 2464 | 2465 | 2466 | 2467 | 2468 | 2469 | 2470 | 2471 | 2472 | 2473 | 2474 | 2475 | 2476 | 2477 | 2478 | 2479 | 2480 | 2481 | 2482 | 2483 | 2484 | 2485 | 2486 | 2487 | 2488 | 2489 | 2490 | 2491 | 2492 | 2493 | 2494 | 2495 | 2496 | 2497 | 2498 | 2499 | 2500 | 2501 | 2502 | 2503 | 2504 | 2505 | 2506 | 2507 | 2508 | 2509 | 2510 | 2511 | 2512 | 2513 | 2514 | 2515 | 2516 | 2517 | 2518 | 2519 | 2520 | 2521 | 2522 | 2523 | 2524 | 2525 | 2526 | 2527 | 2528 | 2529 | 2530 | 2531 | 2532 | 2533 | 2534 | 2535 | 2536 | 2537 | 2538 | 2539 | 2540 | 2541 | 2542 | 2543 | 2544 | 2545 | 2546 | 2547 | 2548 | 2549 | 2550 | 2551 | 2552 | 2553 | 2554 | 2555 | 2556 | 2557 | 2558 | 2559 | 2560 | 2561 | 2562 | 2563 | 2564 | 2565 | 2566 | 2567 | 2568 | 2569 | 2570 | 2571 | 2572 | 2573 | 2574 | 2575 | 2576 | 2577 | 2578 | 2579 | 2580 | 2581 | 2582 | 2583 | 2584 | 2585 | 2586 | 2587 | 2588 | 2589 | 2590 | 2591 | 2592 | 2593 | 2594 | 2595 | 2596 | 2597 | 2598 | 2599 | 2600 | 2601 | 2602 | 2603 | 2604 | 2605 | 2606 | 2607 | 2608 | 2609 | 2610 | 2611 | 2612 | 2613 | 2614 | 2615 | 2616 | 2617 | 2618 | 2619 | 2620 | 2621 | 2622 | 2623 | 2624 | 2625 | 2626 | 2627 | 2628 | 2629 | 2630 | 2631 | 2632 | 2633 | 2634 | 2635 | 2636 | 2637 | 2638 | 2639 | 2640 | 2641 | 2642 | 2643 | 2644 | 2645 | 2646 | 2647 | 2648 | 2649 | 2650 | 2651 | 2652 | 2653 | 2654 | 2655 | 2656 | 2657 | 2658 | 2659 | 2660 | 2661 | 2662 | 2663 | 2664 | 2665 | 2666 | 2667 | 2668 | 2669 | 2670 | 2671 | 2672 | 2673 | 2674 | 2675 | 2676 | 2677 | 2678 | 2679 | 2680 | 2681 | 2682 | 2683 | 2684 | 2685 | 2686 | 2687 | 2688 | 2689 | 2690 | 2691 | 2692 | 2693 | 2694 | 2695 | 2696 | 2697 | 2698 | 2699 | 2700 | 2701 | 2702 | 2703 | 2704 | 2705 | 2706 | 2707 | 2708 | 2709 | 2710 | 2711 | 2712 | 2713 | 2714 | 2715 | 2716 | 2717 | 2718 | 2719 | 2720 | 2721 | 2722 | 2723 | 2724 | 2725 | 2726 | 2727 | 2728 | 2729 | 2730 | 2731 | 2732 | 2733 | 2734 | 2735 | 2736 | 2737 | 2738 | 2739 | 2740 | 2741 | 2742 | 2743 | 2744 | 2745 | 2746 | 2747 | 2748 | 2749 | 2750 | 2751 | 2752 | 2753 | 2754 | 2755 | 2756 | 2757 | 2758 | 2759 | 2760 | 2761 | 2762 | 2763 | 2764 | 2765 | 2766 | 2767 | 2768 | 2769 | 2770 | 2771 | 2772 | 2773 | 2774 | 2775 | 2776 | 2777 | 2778 | 2779 | 2780 | 2781 | 2782 | 2783 | 2784 | 2785 | 2786 | 2787 | 2788 | 2789 | 2790 | 2791 | 2792 | 2793 | 2794 | 2795 | 2796 | 2797 | 2798 | 2799 | 2800 | 2801 | 2802 | 2803 | 2804 | 2805 | 2806 | 2807 | 2808 | 2809 | 2810 | 2811 | 2812 | 2813 | 2814 | 2815 | 2816 | 2817 | 2818 | 2819 | 2820 | 2821 | 2822 | 2823 | 2824 | 2825 | 2826 | 2827 | 2828 | 2829 | 2830 | 2831 | 2832 | 2833 | 2834 | 2835 | 2836 | 2837 | 2838 | 2839 | 2840 | 2841 | 2842 | 2843 | 2844 | 2845 | 2846 | 2847 | 2848 | 2849 | 2850 | 2851 | 2852 | 2853 | 2854 | 2855 | 2856 | 2857 | 2858 | 2859 | 2860 | 2861 | 2862 | 2863 | 2864 | 2865 | 2866 | 2867 | 2868 | 2869 | 2870 | 2871 | 2872 | 2873 | 2874 | 2875 | 2876 | 2877 | 2878 | 2879 | 2880 | 2881 | 2882 | 2883 | 2884 | 2885 | 2886 | 2887 | 2888 | 2889 | 2890 | 2891 | 2892 | 2893 | 2894 | 2895 | 2896 | 2897 | 2898 | 2899 | 2900 | 2901 | 2902 | 2903 | 2904 | 2905 | 2906 | 2907 | 2908 | 2909 | 2910 | 2911 | 2912 | 2913 | 2914 | 2915 | 2916 | 2917 | 2918 | 2919 | 2920 | 2921 | 2922 | 2923 | 2924 | 2925 | 2926 | 2927 | 2928 | 2929 | 2930 | 2931 | 2932 | 2933 | 2934 | 2935 | 2936 | 2937 | 2938 | 2939 | 2940 | 2941 | 2942 | 2943 | 2944 | 2945 | 2946 | 2947 | 2948 | 2949 | 2950 | 2951 | 2952 | 2953 | 2954 | 2955 | 2956 | 2957 | 2958 | 2959 | 2960 | 2961 | 2962 | 2963 | 2964 | 2965 | 2966 | 2967 | 2968 | 2969 | 2970 | 2971 | 2972 | 2973 | 2974 | 2975 | 2976 | 2977 | 2978 | 2979 | 2980 | 2981 | 2982 | 2983 | 2984 | 2985 | 2986 | 2987 | 2988 | 2989 | 2990 | 2991 | 2992 | 2993 | 2994 | 2995 | 2996 | 2997 | 2998 | 2999 | 3000 | 3001 | 3002 | 3003 | 3004 | 3005 | 3006 | 3007 | 3008 | 3009 | 3010 | 3011 | 3012 | 3013 | 3014 | 3015 | 3016 | 3017 | 3018 | 3019 | 3020 | 3021 | 3022 | 3023 | 3024 | 3025 | 3026 | 3027 | 3028 | 3029 | 3030 | 3031 | 3032 | 3033 | 3034 | 3035 | 3036 | 3037 | 3038 | 3039 | 3040 | 3041 | 3042 | 3043 | 3044 | 3045 | 3046 | 3047 | 3048 | 3049 | 3050 | 3051 | 3052 | 3053 | 3054 | 3055 | 3056 | 3057 | 3058 | 3059 | 3060 | 3061 | 3062 | 3063 | 3064 | 3065 | 3066 | 3067 | 3068 | 3069 | 3070 | 3071 | 3072 | 3073 | 3074 | 3075 | 3076 | 3077 | 3078 | 3079 | 3080 | 3081 | 3082 | 3083 | 3084 | 3085 | 3086 | 3087 | 3088 | 3089 | 3090 | 3091 | 3092 | 3093 | 3094 | 3095 | 3096 | 3097 | 3098 | 3099 | 3100 | 3101 | 3102 | 3103 | 3104 | 3105 | 3106 | 3107 | 3108 | 3109 | 3110 | 3111 | 3112 | 3113 | 3114 | 3115 | 3116 | 3117 | 3118 | 3119 | 3120 | 3121 | 3122 | 3123 | 3124 | 3125 | 3126 | 3127 | 3128 | 3129 | 3130 | 3131 | 3132 | 3133 | 3134 | 3135 | 3136 | 3137 | 3138 | 3139 | 3140 | 3141 | 3142 | 3143 | 3144 | 3145 | 3146 | 3147 | 3148 | 3149 | 3150 | 3151 | 3152 | 3153 | 3154 | 3155 | 3156 | 3157 | 3158 | 3159 | 3160 | 3161 | 3162 | 3163 | 3164 | 3165 | 3166 | 3167 | 3168 | 3169 | 3170 | 3171 | 3172 | 3173 | 3174 | 3175 | 3176 | 3177 | 3178 | 3179 | 3180 | 3181 | 3182 | 3183 | 3184 | 3185 | 3186 | 3187 | 3188 | 3189 | 3190 | 3191 | 3192 | 3193 | 3194 | 3195 | 3196 | 3197 | 3198 | 3199 | 3200 | 3201 | 3202 | 3203 | 3204 | 3205 | 3206 | 3207 | 3208 | 3209 | 3210 | 3211 | 3212 | 3213 | 3214 | 3215 | 3216 | 3217 | 3218 | 3219 | 3220 | 3221 | 3222 | 3223 | 3224 | 3225 | 3226 | 3227 | 3228 | 3229 | 3230 | 3231 | 3232 | 3233 | 3234 | 3235 | 3236 | 3237 | 3238 | 3239 | 3240 | 3241 | 3242 | 3243 | 3244 | 3245 | 3246 | 3247 | 3248 | 3249 | 3250 | 3251 | 3252 | 3253 | 3254 | 3255 | 3256 | 3257 | 3258 | 3259 | 3260 | 3261 | 3262 | 3263 | 3264 | 3265 | 3266 | 3267 | 3268 | 3269 | 3270 | 3271 | 3272 | 3273 | 3274 | 3275 | 3276 | 3277 | 3278 | 32 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|-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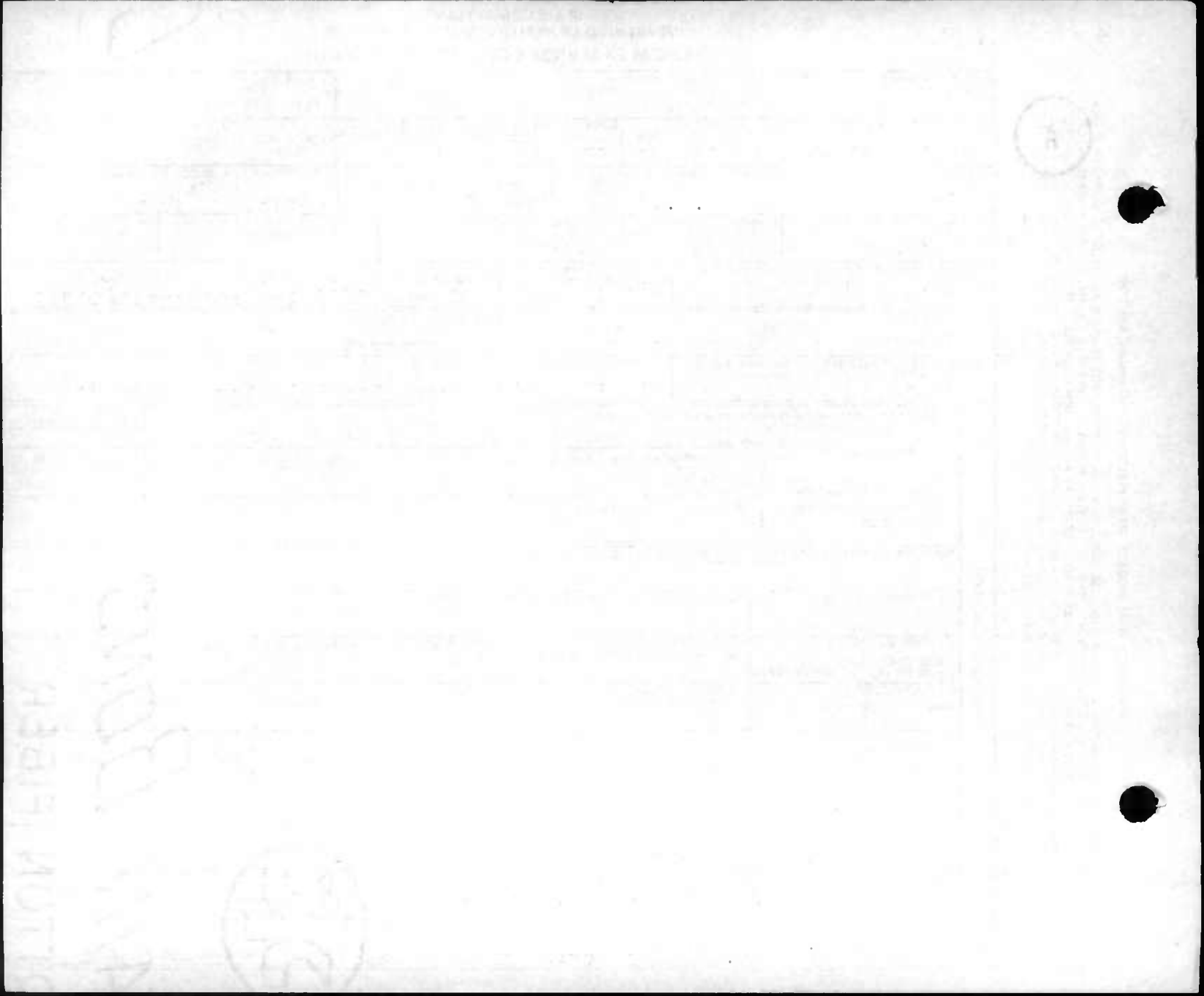


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| FOR STATE REGISTRAR  |  |                  |  |  |  |   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |   |  |  |  |  |  | 1 3 4 2 1<br>REG. NO.          |  |                                |  |
|--|--|------------------|--|--|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Eva McCoy Stewart   |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>5-18 19 84   |  |  |  |   |  |  |  |  |  | 2b. HOUR<br>M<br>12:24<br>P.M. |  |                                |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 10 02  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>81 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS<br>HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-18 19 84     |  |   |  |  |  |  |  |                                |  | 2d. HOUR<br>M<br>12:24<br>P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |   |  |  |  |  |  |                                |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1834 Lorman Street |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |  |  |                                |  |                                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |  |  | 13e. STREET ADDRESS<br>1834 Lorman Street 21217                                     |  |  |  |  |  |                                |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George McCoy   |  |                  |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Unknown   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-16-8084   |  |   |  | 17. INFORMANT ADDRESS<br>Edward Lee 1818 Lorman Street  |  |   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |  |  |   |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |                                |  |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |                  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                |  |                                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.  |  |                  |  |  |  |   |  |   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |  | DATE SIGNED<br>5-18-84  |  |  |  |  |  |                                |  |                                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                  |  |  |  |   |  |   |  | ADDRESS<br>111 Penn Street  |  |  |  |   |  |  |  |  |  |                                |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |                  |  | 23b. DATE<br>5/23/84   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National Cem.  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |   |  |  |  |  |  |                                |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.  |  |                  |  |  |  |   |  |   |  | ADDRESS<br>1101 E North Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Lia Davidson-Randall |  |                                |  |                                |  |



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PENTAGON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 4 2 2

1 - FOR  
STATE  
REGISTRAR

|   |  |                  |  |   |  |   |  |   |  |   |  |  |  |
|---|--|------------------|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Joseph  |  | MIDDLE<br>Stewart   |  | LAST<br>Stewart                                       |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>5-31 1984  |  | 2b. HOUR<br>8:20 P.M.   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 14 14   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>69 YRS.       |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6-1 1984                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1010 W. Baltimore St., Apt. 305 |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>21223  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |                  |  | 13b. COUNTY<br>Baltimore  |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13. STREET ADDRESS<br>1010 W. Baltimore St.                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Glen Stewart  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Willie Mae Farmer  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>240-01-5833  |  |   |  | 17. INFORMANT ADDRESS<br>Geneva Blackburn 2547 Round Rd.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
|   |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Carcinoma of Lung  |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.   |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>6-2-84   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>6/7/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem. |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1984           |  | 25b. REGISTRAR'S SIGNATURE<br>John W. Smith   |  |   |  |  |  |

1987

1987

BP

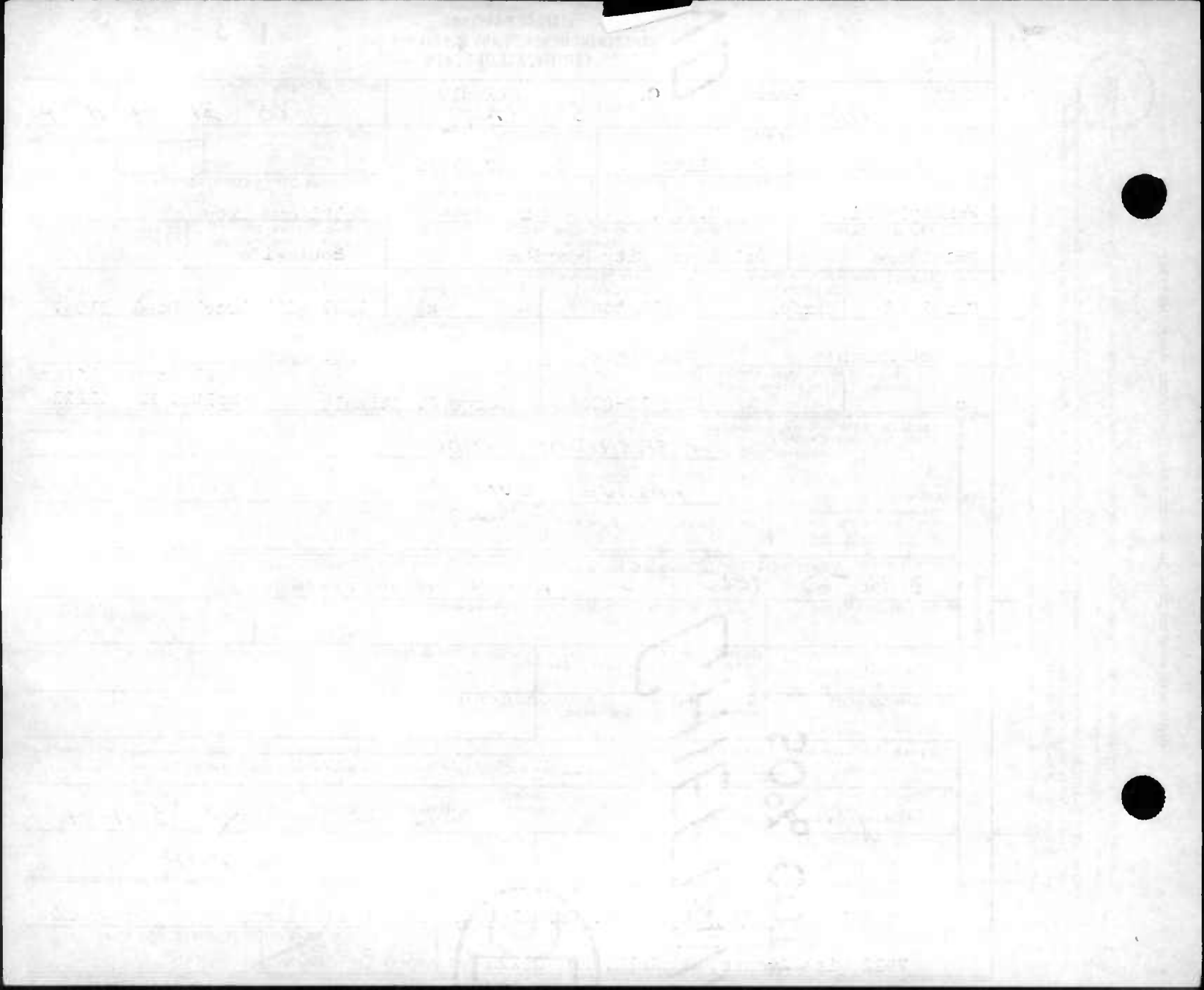
DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 4   |  | 1 3 4 2 3  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE C. STIEMLY</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 31 84</b>  |  | 2b. HOUR<br><b>11<sup>00</sup> P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 29 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>88</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13e. STREET ADDRESS   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Harford</b>   |  | 13c. CITY OR TOWN<br><b>Fallston</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Not Known</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not Known</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-18-8208</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>George J. Stiemly</b>  |  | 17. ADDRESS<br><b>8431 Kavanagh Road<br/>Balto. MD 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE CVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>DIABETES MELLITUS RENAL INSUFFICIENCY</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mary Korytkowski</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>5-31-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. KORITKOWSKI</b>  |  |   |  | 22e. ADDRESS<br><b>BALTIMORE CITY HOSPITALS</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/5/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue, Dundalk, MD 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. B. Borden</b>  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04 13424

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |   |   |
|---|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHRISTINE M. STONES</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 31, 1984</b>  |  | 2b. HOUR<br><b>10:09pm</b>  |   |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>B</b>                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 11 26</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herbert Stones</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lee O'Nora Hatcher</b>   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unkn</b> |  | 16b. SOCIAL SECURITY NO.<br><b>220-22-1386</b>   |   | 17. INFORMANT ADDRESS<br><b>Stephanie K. Davis 4409 Pen Lucy Rd.</b> |   |   |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>3484</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>BRAINSTEM COMPRESSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CEREBELLAR MASS WITH HERNIATION</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MINUTES</b><br><b>3 DAYS</b><br><b>3 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/28</b> , 19 <b>84</b> , to <b>5/31</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>ICEM Boglem</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/31/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6/4/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemete</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie MD</b>   |  | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUN 4 1984</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W.C. March F/H, Inc. 1101 E. North</b>   |  |  |  |  |  |

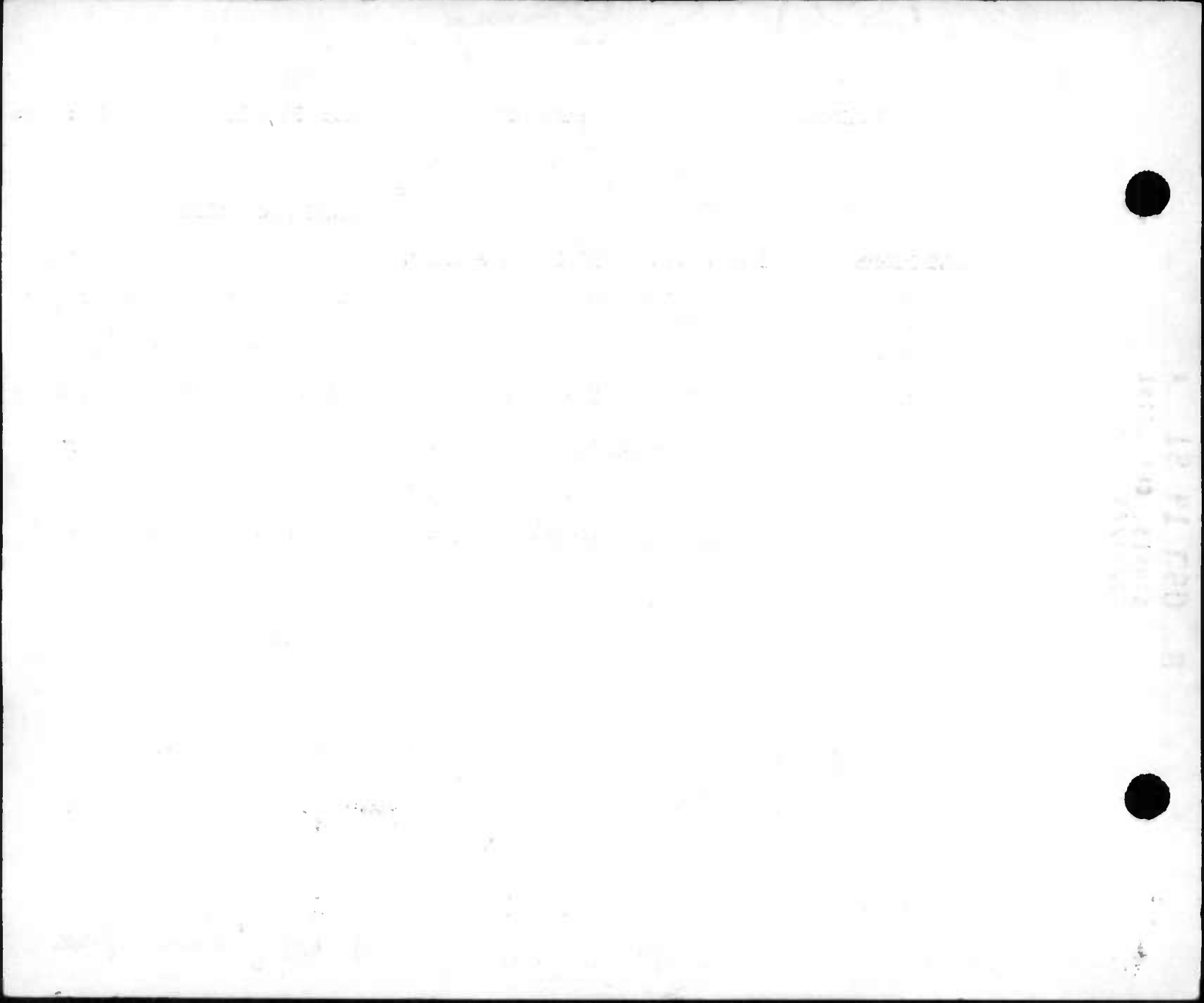
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that each certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in 15 minutes after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STONES, CHRISTINE





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |
|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH T. STONE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 31 84</b> |   | 2b. HOUR<br><b>9:23PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 9 23</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>  |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Stone</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie M. Pryor</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-9099</b>   |  | 17. INFORMANT ADDRESS<br><b>Catherine Tucker 621 East 30th Street</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>0389 IMMEDIATE CAUSE (a) CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____       |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-10 MINS</b><br><b>2 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 29</b> , 19 <b>84</b> , to <b>MAY 31</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>MAY 31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Kevin Boylan</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/31/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEVIN BOYLAN, M.D.</b>   |  | 22e. ADDRESS<br><b>600 N. WOLFE BALTO., MD. 21205</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>6/8/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |   |   |  |
| 25a. DATE REC'D BY REGISTRAR<br><b>JUN 4 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>   |  |   |   |  |

BP

TO THE BOARD OF

WICT

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 2 6

REG. NO.

|  |  |  |   |   |   |   |   |  |  |
|--|--|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Stoops, R. MARIE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 12 84</b>                         |   |   | 2b. HOUR<br><b>6 A M</b>  |   |  |  |
| 3. SEX<br><b>Fem.</b>  |  | 4. RACE<br><b>Cau.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 2 1887</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Convalesarium</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>                                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Peters</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Flading</b>      |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>6308 Brook Ave. 21206</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-03-1855</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Charlotte A. Quigley 6308 Brook Ave.</b> |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>ATHEROSCLEROTIC CARDIOVASCULAR</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>DISEASE</b> |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>DIABETES MELLITUS</b>   |  |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(A HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Rivera</b>  |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RIVERA</b>   |  |  | 22e. ADDRESS  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>5-15-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b>           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Balto. Md.</b>                          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc. 6415 Belair Rd.</b>   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Switzer Randall</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (a), (b) or (c), item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified in item 18.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 2 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN S. STOUT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/26/84</b>                                |   | 2b. HOUR<br><b>5:15 AM</b>                           |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 20 1903</b>   |  |  |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>80</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.   |  |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                                   |   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>101 W. Northern Pkwy. 21210</b>   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William G. Scarlett</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Hooper Lazenby</b>          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-7663</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>Charles L. Stout Balto., Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>Left Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>Diabetes Mellitis</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5/25</b> , 19 <b>84</b> , to <b>5/26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                          |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Visings</b> DEGREE <b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>5/26/84</b>   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT VISSING</b>   |  |  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-29-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>29 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randell</b>  |  |

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WASHINGTON CITY UNION MEMORIAL HOSPITAL  
1111 Northern Pkwy.  
N.W.  
Washington, D.C. 20004  
Phone: 222-7000  
Telex: 222-7000  
Fax: 222-7000  
E-mail: info@wumh.org  
Web: www.wumh.org

Henry J. Jenkins & Sons Co., Baltimore, Md.  
1-22-14 David L. Jenkins  
Licensing & Sales, Md.  
1-22-14

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO

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|---|--|--|--|--|--|--|--|--------------------------------|--|--------|--|--------|--|------------|--|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH              |  | MONTH  |  | DAY    |  | YEAR       |  | 2b. HOUR                        |  |
| JAMES   |  | STOVALL  |  |  |  |  |  | 5/11/84                        |  | 3      |  | 35     |  | AM         |  |                                 |  |
| 3. SEX  |  | Male   |  | 4. RACE  |  | Black  |  | 5. DATE OF BIRTH               |  | MONTH  |  | DAY    |  | YEAR       |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |
|   |  |  |  |  |  |  |  | Aug                            |  | 9      |  | 1898   |  | 85         |  | YRS.                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                                |  |        |  |        |  |            |  |                                 |  |
| Georgia   |  | U.S.A.   |  |  |  | BALTIMORE  |  |                                |  |        |  |        |  |            |  |                                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                |  |        |  |        |  |            |  |                                 |  |
| BALTIMORE CITY  |  | UNION MEMORIAL HOSPITAL  |  | Pipe Fitter  |  | Gas & Electric Co.   |  |                                |  |        |  |        |  |            |  |                                 |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE |  |        |  |        |  |            |  |                                 |  |
| Maryland  |  |  |  | Baltimore  |  |  |  | 2630 Boone Street - 21218      |  |        |  |        |  |            |  |                                 |  |
| 14. FATHER'S NAME   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME       |  | FIRST  |  | MIDDLE |  | LAST       |  |                                 |  |
| Henry   |  |  |  |  |  | Stovall  |  | Rosie                          |  |        |  |        |  | Washington |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |                                |  |        |  |        |  |            |  |                                 |  |
| No  |  | 218-10-1991  |  | Theodore Stovall - 61 Buena Vista Ave.,  |  | Piscataway, N.J.   |  |                                |  |        |  |        |  |            |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | Pulmonary edema  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                |  |        |  |        |  |            |  |                                 |  |
| 4100  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (b) Chronic renal failure  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c) Acute myocardial infarction  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  | bradycardia, hypothermia, hypothyroidism   |  |  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |                                |  |        |  |        |  |            |  |                                 |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                |  |        |  |        |  |            |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY                         |  | STATE  |  |        |  |            |  |                                 |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/7, 1984, to 5/11, 1984, that (1) (we) last saw the deceased alive on 5/11/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED               |  |        |  |        |  |            |  |                                 |  |
|   |  | ALICIA COOL-FOBY   |  | MD   |  |  |  | 5/11/84                        |  |        |  |        |  |            |  |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
|   |  | UNION MEMORIAL HOSPITAL  |  |  |  |  |  |                                |  |        |  |        |  |            |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | CITY OR TOWN                   |  | COUNTY |  | STATE  |  |            |  |                                 |  |
| Burial  |  | May 16, 1984   |  | Arbutus Memorial Pk.   |  | Baltimore  |  | Md.                            |  |        |  |        |  |            |  |                                 |  |
| 24. FUNERAL DIRECTOR  |  | 2501 Gwynns Falls Pkwy., Balto., Md.   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                                |  |        |  |        |  |            |  |                                 |  |
| Nutter and Sons Funeral Home, Inc.  |  |  |  | MAY 15 1984  |  | Lila Davidson-Randall  |  |                                |  |        |  |        |  |            |  |                                 |  |

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Co.

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918-10-1991 Theodore Stovall - 61 Santa Vista Ave.,

10. Excluded

• *Intervju a studenta*

1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 26

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## Intro

Letter to Scott Perry

• 21, 22.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, shows any injury, or other traumatic event, the medical examiner must be notified in case of a medicolegal death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WALTER T. STRAWN</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 6 84</b> |   | 2b. HOUR<br><b>7:20 PM</b>                   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 14 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>72</b>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b>                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oliver Strawn</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Stella Young</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2330 N. Monroe St. 21217</b>                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-01-9862</b>  |  | 17. INFORMANT<br>ADDRESS <b>Frederick, Md.</b><br><b>Stella C. Tyler 49 Apple Way. 21701</b>    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <b>5/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>UDOH OBLOTHA, MD</b>  |   | 22e. ADDRESS<br><b>2600 4th BERTY HIGH BAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>5/11/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |   | ADDRESS<br><b>1101 E North Ave.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                                |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

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WALTER T. STEPHENSON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 4 1 3 4 3 0<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |  |
| FIRST MIDDLE LAST<br><b>William Strickland</b>   |  |   |  | MONTH DAY YEAR<br><b>May 29, 1984</b>   |  |  |  | <b>4:10PM</b>   |  |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 74 HRS.  |  |
| <b>Male</b>  |  | <b>Black</b>  |  | MONTH DAY YEAR<br><b>3-7-26</b>   |  | <b>58</b> YRS.   |  | MONTHS DAYS   |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| <b>Baltimore</b>   |  | <b>U.S.</b>   |  |   |  | <b>Baltimore City</b> MD   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| <b>Baltimore</b>   |  | <b>Maryland General Hospital</b>  |  |   |  |  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?  |  |  |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |   |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | <b>4201 Mondawmin Ave.</b>  |  |   |  |
| <b>Md.</b>   |  |   |  | <b>Baltimore</b>  |  |  |  |   |  |   |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |
| FIRST MIDDLE LAST<br><b>William Rufus Strickland</b>   |  |   |  | FIRST MIDDLE LAST<br><b>Cleopatra</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |
|  |  |   |  | <b>4212-20-5718</b>   |  | <b>Willie Mae Strickland</b>   |  | <b>4201 Mondawmin</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) <b>Uremia</b>  |  |   |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hyperkalemia</b>  |  |   |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive Heart Failure</b>  |  |   |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |
|  |  |   |  |   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY STATE  |  |
|  |  |   |  |   |  |  |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to <b>May 29</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 29</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Michael Yen, M.D.</b>   |  |   |  |   |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>5/30/84</b>                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  |  |  | 22e. ADDRESS  |  |   |  |
| <b>Michael Yen, M.D.</b>   |  |   |  |   |  |  |  | <b>C/O Maryland General Hospital</b>                                |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |
| <b>Burial</b>  |  |   |  | <b>6-2-84</b>   |  | <b>Md. NATIONAL PARK LAUREL</b>  |  | <b>Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| <b>IRVIN CARROLL</b>   |  |   |  | <b>1712 W. NORTH AVE</b>  |  | <b>MAY 29 1984</b>   |  | <b>Julia Davidson-Randall</b>                                       |  |   |  |

THE SECRETARY  
OF THE  
TREASURY

RECEIVED  
JAN 10 1934  
U.S. DEPT. OF THE TREASURY

WASHINGTON, D.C.

JAN 10 1934

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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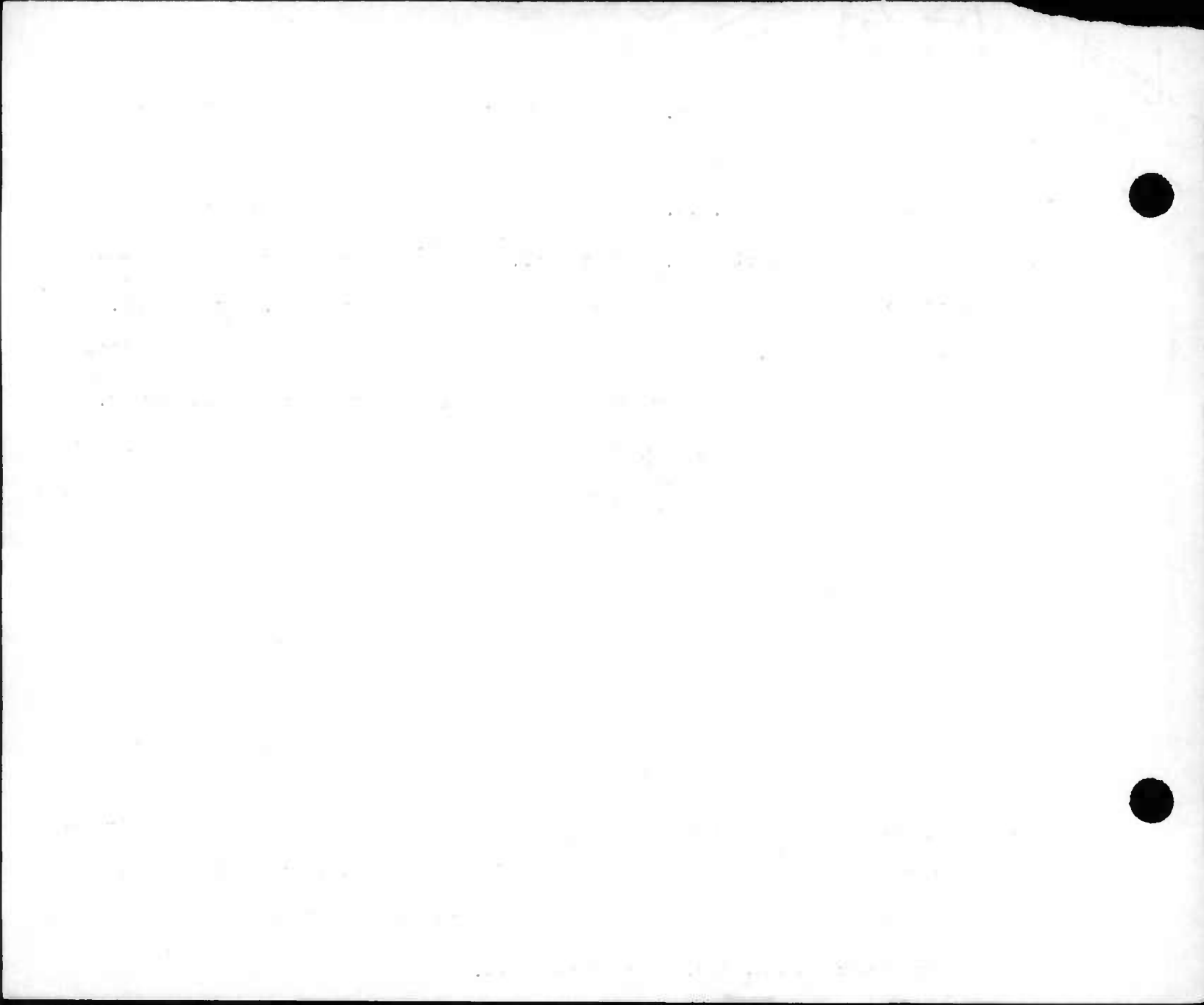
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 3 1

|  |         |  |                                 |  |  |
|--|---------|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| EDNA M. STUMP  |         | 5 25 84  |                                 | 1:00 PM  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR  |  |
| Female   | White   | 7 19 08  | 75                              | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland   |         | U.S.A.   |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Baltimore  |         | Christ Ch. Harbor Apts. 600 Light St.  |                                 | Homemaker  |  |
| 13a. STATE   |         | 13b. COUNTY  |                                 | 13c. CITY OR TOWN  |  |
| Maryland   |         |  |                                 | Baltimore  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |
| John F. Riggs  |         | Bessie Kane  |                                 | NO   |  |
| 16b. SOCIAL SECURITY NO.   |         | 17. INFORMANT  |                                 | ADDRESS  |  |
| 220-46-4143  |         | Wayne A. Stollenmaier  |                                 | 1106 Plover Dr. 21227  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |         |  |                                 |  |  |
| 4100 IMMEDIATE CAUSE (a) Myocardial infarction   |         |  |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerotic cardiovascular disease   |         |  |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF: (c) acute  |         |  |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |                                 |  |  |
| adenocarcinoma of colon  |         |  |                                 |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20a. AUTOPSY?  |  |
|  |         |  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY  |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|  |         | HOUR A.M. MONTH DAY YEAR   |                                 |  |  |
|  |         | P.M. 19  |                                 |  |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)   |                                 | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |                                 | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 16 1984 to May 16 1984 that (I) (we) last saw the deceased on May 16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                                 |  |  |
| 22b. SIGNATURE   |         |  |                                 | 22c. DATE SIGNED   |  |
| Salvatore J. Demarco III   |         |  |                                 | 27 May 84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         |  |                                 | 22e. ADDRESS   |  |
| Salvatore J. Demarco III   |         |  |                                 | 333 St. Paul Street; Baltimore 21202   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |         | 5/29/84  |                                 | Loudon Park Cemetery   |  |
| 23d. LOCATION  |         | 23e. NAME OF CEMETERY OR CREMATORY   |                                 | 23f. LOCATION  |  |
| Baltimore  |         | Baltimore  |                                 | Baltimore  |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE RECEIVED BY REGISTRAR  |                                 | 25b. REGISTRAR'S SIGNATURE   |  |
| NAME ADDRESS   |         | MAY 29 1984  |                                 | John Davidson-Randall  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |         |  |                                 |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 13432

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE SOPHIE SUMAN</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 28, 1984</b>  |  | 2b. HOUR<br><b>7:08 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 14, 1899</b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>84 YRS.</b>                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Res. Home</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                       |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Brooklyn Park</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lewis W. Suman</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cora Gilbert</b>  |  | 13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214/01/3258</b>   |  | 17. INFORMANT (Niece) ADDRESS<br><b>Betty J. Cook 203 Ninth Ave. SE Glen Burnie, Md</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction</b><br>4100<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/29</b> , 19 <b>84</b> , to <b>5/28</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>AL/moo A. O'Hara</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>5/28/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALFONSO A. O'HARA</b>  |  | 22e. ADDRESS<br><b>3001 St Remond St Baltimore Md</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 31, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                        |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Singleton Funeral Home</b>   |  | ADDRESS<br><b>Glen Burnie, Md</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Fred. Md.</b>                             |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. C. Kinsler</b>   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 13e per ph. 5/23/84 kh   |  |  |  |  |  |  |   |  |   | STATE OF MARYLAND                  |  |
|---|--|--|--|--|--|--|---|--|---|------------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |   |  |   | 84 13433                           |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |   |  |   | REG. NO.                           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HERBERT J SUMRELL</b>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 15 84</b>                             |  |   | 2b. HOUR<br><b>6:28 PM</b>   |   |                                    |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 9 15</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |   |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |   |  |   |                                    |  |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1939 Clifton Avenue 21217</b>   |   |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Sumrell</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beadie Lane</b>                |  |   |  |   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>Josephine Sumrell 7323 Walnut Lane 1913</b>   |  |  |   |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>5109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>empyema and sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>infected pacemaker wires</b><br>Approximate interval between onset and death<br><b>Unknown</b><br><b>~ 2 months</b><br><b>~ 6 months</b> |  |  |  |  |  |  |   |  |   |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Cachexia (protein-calorie malnutrition)</b>  |  |  |  |  |  |  |   |  |   |                                    |  |
| 19a. DATE OF OPERATION<br><b>11/7/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Infected pacemaker</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>83</b> , to <b>MAY 15</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>May 15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |   |  |   |                                    |  |
| 22b. SIGNATURE<br><b>Vincent K. H. Tam, MD</b>  |  |  |  |  | DEGREE<br><b>MD</b>  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/15/84</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Vincent K. H. Tam, MD</b>   |  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21205</b> |  |   |  |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Calhoun</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b> |  |   |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William L. McLean 3207 W. Baltimore Ave</b>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 17 1984</b>                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>        |  |   |                                    |  |

MEDICAL CERTIFICATION

29

1

RECEIVED

22 15 30

1960

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 3 4

REG. NO.

|   |  |  |  |   |  |  |   |  |                                    |   |  |
|---|--|--|--|---|--|--|---|--|------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN SUTTON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/10/84</b>                  |   | 2b. HOUR<br><b>5:25AM</b>  |  |   |  |                                    |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/10/06</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |                                    |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DUKELAND NURS HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                    |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                    | 13e. STREET ADDRESS<br><b>4011 PENHURST AVE 21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>        |   |  |  |   |  |                                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212 076212A</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>RECORDS DUKELAND NURS HOMES</b>                 |  |   |  |                                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |   |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |  |                                    |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |                                    |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/7</b> , 19 <b>84</b> , to <b>5/10</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |   |  |  |   |  |                                    |   |  |
| 22b. SIGNATURE<br><b>Dr. Quinn</b>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>5/10/84</b> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEONINA L. CURE</b>   |  |  | 22e. ADDRESS<br><b>CLIFTERSON HOSPITAL</b>                             |   |  |  |   |  |                                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>5-28-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt 210N</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                                    |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph C. Russo</b>  |  |  | ADDRESS<br><b>2222 W North</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Bar Davidson-Hendell</b>  |                                    |   |  |

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

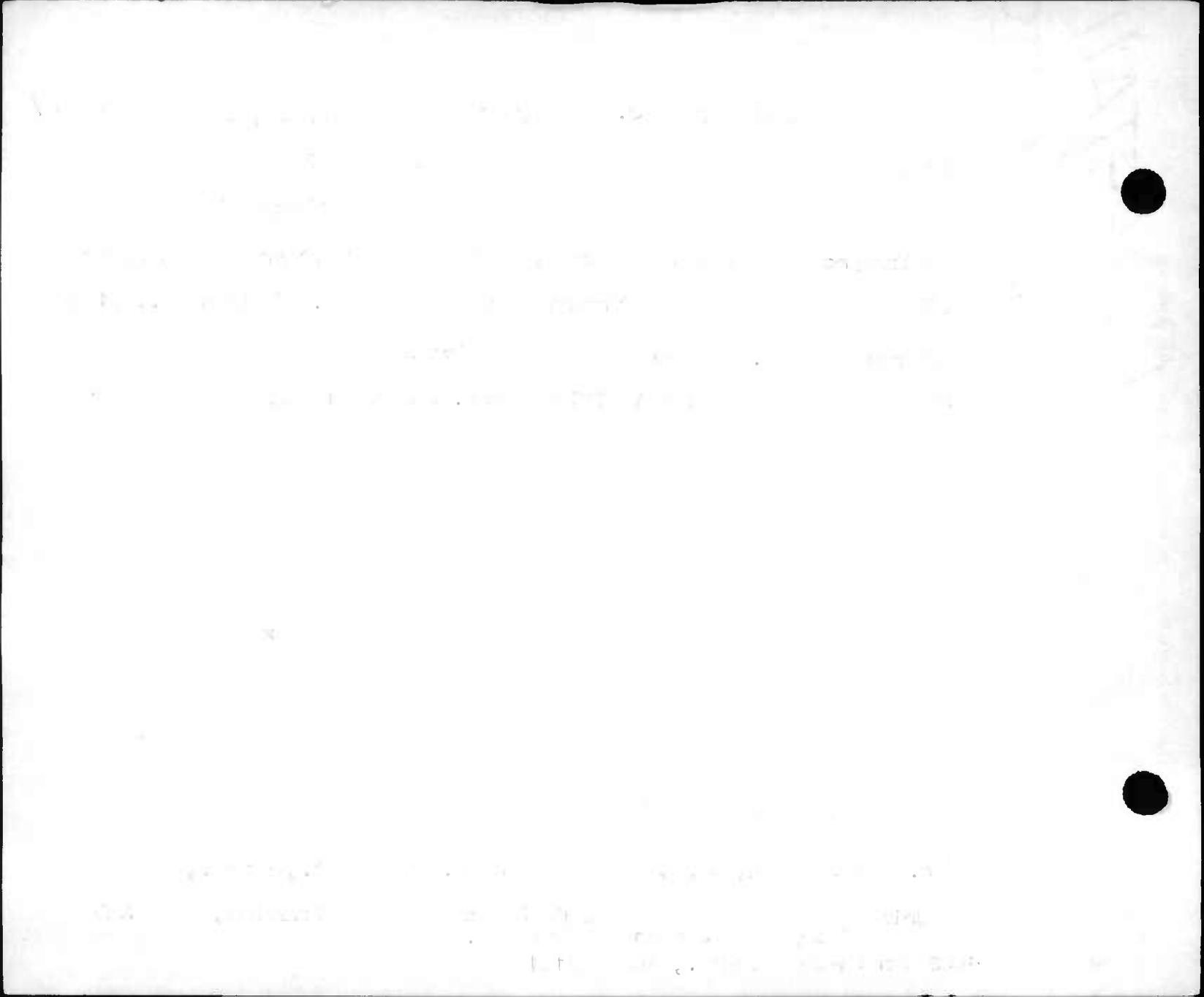
IMPORTANT: If item 21 is marked as "1", it shows only injury, or other traumatic event, the medical examiner must be notified of one.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                 |  |  |
|--|--|--|--|---|--|--|-----------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 854 13435   |  |                 |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ALEXANDER J. SUWALL   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 25, 1984                 |  |                 | 2b. HOUR<br>2:30 a   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 20 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |                 |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Partner  |                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Florist   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                 | 13e. STREET ADDRESS / ZIP CODE<br>7 E. Madison St., 21202  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George M. Suwall   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Wolle |  |                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>103 12 7375   |  | 17. INFORMANT<br>Mrs. Helen Suwall,   |  |  | ADDRESS<br>Same |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4149 IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic HD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u><br><u>Years</u> |  |  |  |   |  |  |                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ca metastasized to Liver</u>   |  |  |  |   |  |  |                 |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                 |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>83</u> , to <u>5/25</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/24/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) see the body after death.   |  |  |  |   |  |  |                 |  |  |
| 22b. SIGNATURE<br><u>Mark Dugan MD</u>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 | 22c. DATE SIGNED<br><u>5/24/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Mark Dugan, M.D.  |  |  |  | 22e. ADDRESS<br>15 E. Biddle St., Balto., MD  |  |  |                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5/28/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, MD   |                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>ADDRESS 4905 York Road Balto., MD 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984  |  | 25b. REGISTRAR'S SIGNATURE   |                 |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | REG. NO. 6413436   |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DORIS MYRTLE SWEET  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 16, 1984                              |  | 2b. HOUR<br>9:00A M   |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6/24/1917  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CONNECTICUT   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL, INC. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>ROSEDALE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7932 35th STREET 21237  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>PHILLIP RUSSELL   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CORA LACKEY   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218.07.4272D  |  | 17. INFORMANT<br>EDWARD SWEET   |  | 17. INFORMANT ADDRESS<br>ROUTE 29 BOX 391 NN<br>Fort Myers, Flor. 33905       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) METASTATIC LIVER DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) FROM CA. RIGHT COLON<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 13, 1984, to May 16, 1984, that (I) (we) last saw the deceased alive on May 16, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I did not) view the body after death.  |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Sompalli Prasad  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SK PRASAD SOMPALLI, M.D.  |  |  |  | 22e. ADDRESS<br>CHURCH HOSPITAL<br>100 N. BROADWAY BALTIMORE, MD 21231  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  | 23b. DATE<br>5/17/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND             |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC DUNDALK, MD. 21222  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 17 1984                                  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randell  |  |  |  |



NAME

WHITE

6/20/1917

66

CONSTITUTION

U.S.A.

X

BALTIMORE CITY

BALTIMORE

CHURCH WORKMAN, INC.

HOMERIDGE

MARYLAND BALTIMORE

ROCKVILLE

X

4005 3RD STREET S.W.

PHILLY

RUSHING

COOK

LAUREL

NO

212 N. 1ST ST. BALTIMORE

ROOM 20 BOX 301 NW  
FORD MERE, MD. 21000

Handwritten signature or initials.

BOX 2001

REMARKS

6/20/1917

CHURCH WORKMAN, INC. BALTIMORE

MARYLAND

WALTER BROOKS BRADLEY, INC. BALTIMORE, MD. 21000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |                                   |   |  |
|---|--|---|--|---|--|--|---|-----------------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 64 13437   |  |   |  |  |   |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH  |  |   |                                   |   |  |
| FIRST MIDDLE LAST<br>Morris L. Tabbs Jr.  |  |   |  |   | MONTH DAY YEAR HOUR<br>May 23, 1984 4:17P M  |  |   |                                   |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE   |   | 7. IF UNDER 1 YEAR                |   |  |
| MALE  |  | NEGROID   |  | MONTH DAY YEAR<br>July 26   |  | 67 YRS.  |   | MONTHS DAYS HOURS MIN.            |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   |                                   |   |  |
| MARYLAND  |  | U.S.A.  |  |   |  | Baltimore City MD.   |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Baltimore   |  | Maryland General Hospital   |  |   |  | Retired  |   | Industry                          |   |  |
| 13a. STATE  |  |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                   | 13d. INSIDE CITY LIMITS?  |  |
| MD.   |  |   |  |   |  |  | BALTO.  |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME   |  |   |                                   |   |  |
| FIRST MIDDLE LAST<br>Morris L. Tabbs Sr.  |  |   |  |   | FIRST MIDDLE LAST<br>Bertha Butler   |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |                                   |   |  |
| Yes   |  |   |  |   | unk  |  | 215-03-5784 Bernice Allen 1418 E. Lafayette Ave.                    |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septic Shock<br>2050 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute Myeloid Leukemia with Pancytopenia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |  |   |                                   |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Hours - 1 Day   |  |   |  |   |  |  |   |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Upper Gastrointestinal Bleed  |  |   |  |   |  |  |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |   |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |                                   | COUNTY STATE  |  |
| 22a. I certify that (x) (this hospital) attended the deceased from March 27, 1984, to May 23, 1984, that (x) (we) last saw the deceased alive on May 23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |                                   |   |  |
| 22b. SIGNATURE<br>Richard L. Loria M.D.   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED                  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Loria, M.D.  |  |   |  |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                   |   |  |
| Burial  |  |   | 5-28-84  |   | Crownsville V.A. Cem.  |  | Annaprindel County Md.  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                                   |   |  |
| Calvin B. Scruggs 1412 E. Preston   |  |   |  |   | MAY 24 1984  |  | Julia Davidson-Randall  |                                   |   |  |

MEDICAL CERTIFICATION

LIBRARY



1 3 4 3 8

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH YEAR DAY  |  | 2b. HOUR   |  |
| WILSON  |  | EDWARD  |  | TALLMAN   |  | MAY 30 1984 0420 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 14, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE, CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NAME OF HOSPITAL OR NURSING HOME OR OTHER INSTITUTION ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Painter   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Frank C. Long   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anderson W. Tallman   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hulda Margaret Sheets  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW II<br>236-10-0957  |  | 17. INFORMANT<br>ADDRESS<br>440 Hillview Drive<br>Nancy C. Wenderoth Linthicum, Md. 21090   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1850 IMMEDIATE CAUSE (a) <u>URINARY OBSTRUCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PROSTATIC CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>BENIGN PROSTATIC HYPERTROPHY</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>DIABETES, ANEMIA</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>5/23/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>HEMATURIA   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>MAY 21</u> , 19 <u>84</u> , to <u>MAY 30</u> , 19 <u>84</u> , that (we) lost saw the deceased alive on <u>MAY 30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Peter G. Wallick</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>5/30/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PETER G. WALLICK M.D.  |  |   |  | 22e. ADDRESS<br>201 UNIVERSITY PARKWAY BALTIMORE, MD 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>May 31, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUN 1 1984 <u>John Davidson Randall</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours prior death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. These should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked as item 18, any injury, or other traumatic event must be completed on page 4.BP \_\_\_\_\_  
DHWH - 16 50M 4/83  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Florence E Tater</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 14 84</b>   |  | 2b. HOUR<br><b>3 A M</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 21 88</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridan Nursing Home (Ingleside)</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3810 Cedardale Road Baltimore, Maryland 21215</b>                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Carey</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Anderson</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-34-9493</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Clarice Watts Baltimore, Maryland 21215</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>A.S.C.V.D</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> 19 <b>84</b> to <b>5/14</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |  |
| 22b. SIGNATURE<br><b>K. Dharmasena M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>5/14/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. DHARMASENA</b>  |  | 22e. ADDRESS<br><b>#8, 16th AVE. Balt. Md 21225</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/17/1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc.</b><br><b>2501 Gwynns Falls Parkway, Baltimore, Md. 21216</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>                                  |   |  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                          |   |  |

1944-1945  
1946-1947  
1948-1949  
1950-1951  
1952-1953  
1954-1955  
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2008-2009  
2010-2011  
2012-2013  
2014-2015  
2016-2017  
2018-2019  
2020-2021  
2022-2023  
2024-2025

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

Items 18-22a 6/4/84 mth F#592

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13440

|  |  |                                     |  |  |  |   |  |   |  |   |  |   |  |
|--|--|-------------------------------------|--|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>John  |  | MIDDLE<br>S.  |  | LAST<br>Tatum   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>5-3 19 84 |  | 2b. HOUR<br>M<br>5:40   |  |
| 3. SEX<br>M  |  | 4. RACE<br>B                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 14 35   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>48 YRS.               |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-3 19 84             |  | 7d. HOUR<br>M<br>5:40   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                     |  |  |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br>MD   |  |                                     |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2408 Guilford Ave. 21218                     |  |   |  |
| 4. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Tatum   |  |                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Mason Tatum  |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-32-7064   |  |   |  | 17. INFORMANT ADDRESS<br>Mae Tatum 2408 Guilford Avenue   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) <u>Primary Intracerebral Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                     |  |  |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                                     |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                   |  |                                     |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |  |                                     |  | TITLE (SPECIFY)<br>MD Assistant  |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>5-4-84   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                                     |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                                     |  | 23b. DATE<br>5/8/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus MD            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.C. March F/H, Inc.   |  |                                     |  | ADDRESS<br>1101 E. North Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984   |  |   |  |   |  |
|  |  |                                     |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeha Davidson-Randall</i>  |  |   |  |   |  |

BP 68



RECEIVED  
JAN 11 1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

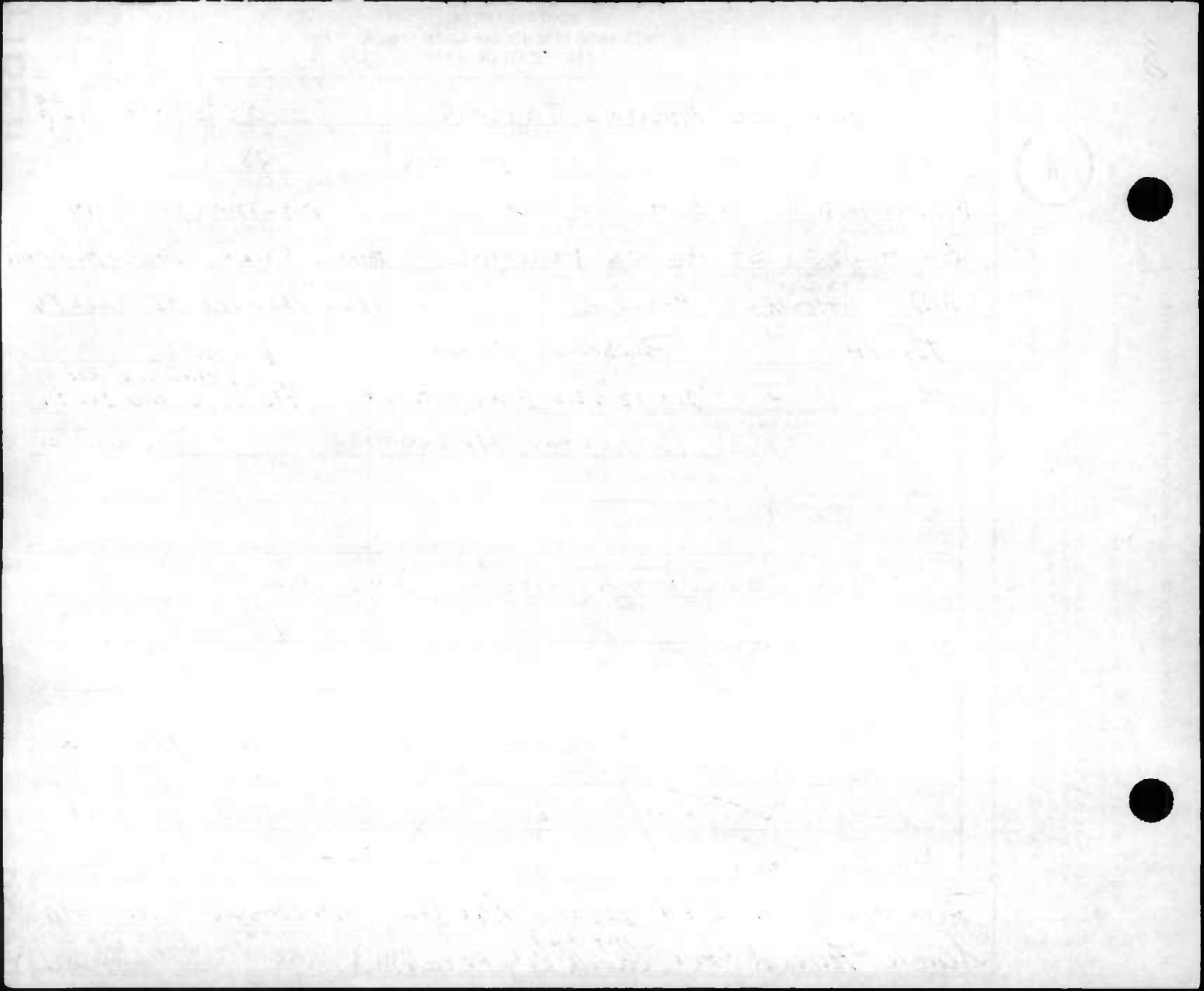
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 4 1

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BLANCHE PARSONS TAYLOR  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05/31/1984   |   | 2b. HOUR<br>12:20 PM  |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 27 1996  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PAYROLL CLERK |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>DAVIS HEMMILL |
| 13a. STATE<br>MD   |   | 13b. COUNTY<br>HOWARD   | 13c. CITY OR TOWN<br>HANOVER  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH PARSONS   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CLARA LUDWIG   |   | 13e. STREET ADDRESS / ZIP CODE<br>6150 HANOVER RD. 21076  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>213-12-6203   |   | 17. INFORMANT<br>ADDRESS<br>BRUCE T. SCHULT<br>6132 HANOVER RD.<br>HANOVER MD 21076             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5789 IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 MINUTES |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110<br>UPON GASTROINTESTINAL BLEEDING, DEHYDRATION  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 29 MAY 19 84 to 31 MAY 19 84, that (1) (we) lost<br>saw the deceased alive on 31 MAY 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br>Andrew Tropea  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>5-31-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andrew Tropea   |   | 22e. ADDRESS<br>900 CARON AVE. BALTIMORE, MD  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>6-2-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LORDON PARK Cem.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MD  |   | 23e. DATE REC'D. BY REGISTRAR<br>JUN 1 1984   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Slack Funeral Home   |   | ADDRESS<br>Bop 268<br>Cecil City, MD  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 4 2

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR  |  |
|   |  | ISABELL TAYLOR  |  | MAY 15, 1984  |  | 8:00pm  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE  |  | BLACK   |  | 02 06 06  |  | 78 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| N.C.  |  | U.S.A.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTO.  |  | CHURCH HOSPITAL   |  | SOC. SERV.  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| md.   |  |   |  | BALTO.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| Richard Spearman  |  | Melissa Wiggins   |  | No  |  | 220-12-5465   |  |
| 17. INFORMANT   |  | ADDRESS   |  | 17. INFORMANT   |  | ADDRESS   |  |
| Ms. Theodora Peters   |  | 1023 Milton Ave   |  | 21213   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 1952  |  | Carcinoma of the - Abdomen  |  | METASTASIS TO LIVER   |  | 2 1/2 weeks   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
|   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
|   |  | P.M. 19   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APR 3, 19 84, to MAY 15, 19 84, that (I) (we) (we) lost<br>saw the deceased alive on MAY 15, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (we) did not view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED  |  |
| George Thomas   |  |   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | CHURCH HOSPITAL   |  |   |  |
| GEORGE K. THOMAS MD   |  | 100 N. BROADWAY BALTO. MD 21231   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| BURIAL  |  | 5-21-84   |  | GARDEN OF HOPE  |  | Westminster md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | REGISTRAR'S SIGNATURE   |  |
| Redd Funeral Home   |  | 5209 YORK RD. 21212   |  | MAY 18 1984   |  | Julia Davidson-Randall  |  |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY TAYLOR</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 8 1984</b>  |  | 2b. HOUR<br><b>10:25</b><br>P                                    |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 7 03</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NC</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy M. White 1408 N. Broadway</b>                            |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gangrene Left Foot</b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b>  |  |   |

|  |  |  |   |
|--|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Diffuse Peripheral Vascular Disease, Hypertension</b>   |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 19</b> , 19 <b>84</b> , to <b>May 8</b> , 19 <b>84</b> , that the deceased was alive on <b>May 8</b> , 19 <b>84</b> , and that in my opinion death occurred on the date and hour and from the causes stated above. Dr. (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Luzviminda K. Penezo MD</b>   |  | 22c. DATE SIGNED<br><b>5/5/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luzviminda K. Penezo</b>   |  | 22e. ADDRESS<br><b>100 N. Broadway Baltimore, Md</b><br><b>Church Hospital 21231</b> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>5/12/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD</b>  |

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. March Funeral Home</b> | ADDRESS<br><b>1101 E North Ave</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b> | 25b. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randall</b> |
|---|------------------------------------|--|--|

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner must be notified and signed.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 4 4 4  
REG. NO.

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Teenie Taylor</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 9, 1984</b> |   | 2b. HOUR<br><b>9a.</b> M   |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8, 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2407 Talbott Road</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2716 Harlem Ave. 21216</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Miller</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Spencer</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-22-6265</b>  |   | 17. INFORMANT ADDRESS<br><b>Walter Miller 2716 Harlem Ave.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19____, to <b>1984</b> , 19____, that (I) (we) last saw the deceased alive on <b>Aug 23</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Richard M. Hunt MD</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5-11-84</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD M. HUNT MD</b>   |  |   |   | 22e. ADDRESS<br><b>900 Broadbush Ave -</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-14-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, P.C. Maryland</b>                                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles A. Rice Funeral Ser. P.A.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 18 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

BP





REG. NO.

BP\_\_\_\_\_

MH - 16 50M 4/8

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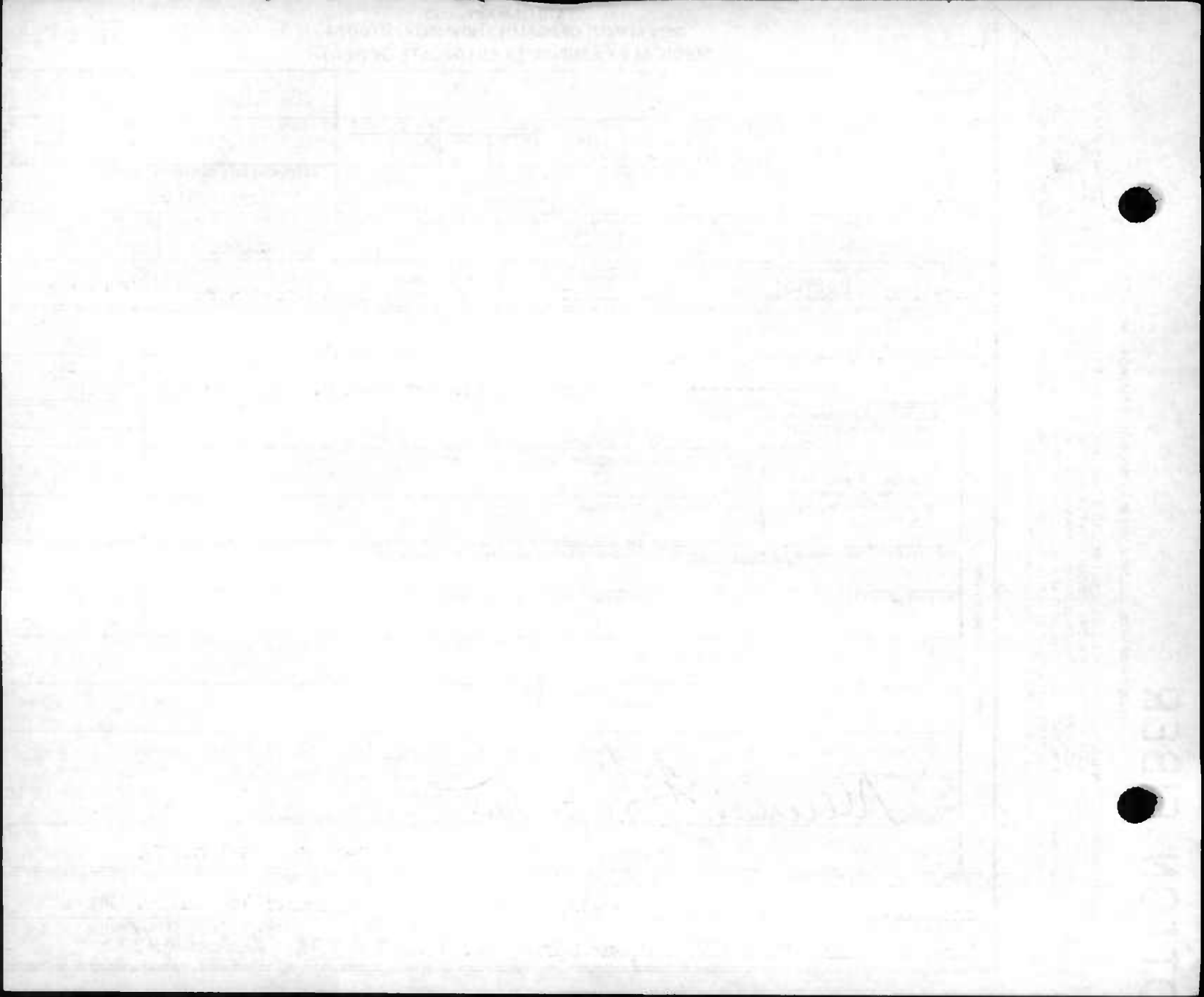
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |   |   |   |   |   |   |  | REG. NO. 13446  |  |
|---|--|-------------------------------------|---|---|---|---|---|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |                                     |   |   |   |   |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>John W. Teal   |  |                                     |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>5 7 1984                                 |   | 2b. HOUR<br>M                                  |   |  |
| 3. SEX<br>male  |  | 4. RACE<br>white                    |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 30, 1935          |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>48                                 |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 7 1984                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2663 Hafer Street |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>grounds keeper                 |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>cemetery                                       |  |
| 13a. STATE<br>Maryland  |  |                                     | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>2663 Hafer Street 21223 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter F. Teal  |  |                                     |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Martin   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>212-34-3910   |   | 17. INFORMANT<br>ADDRESS<br>Ms. Margaret G. Teal 1029 Quantril Rd/ 21205  |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cirrhosis</u><br>5715<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                                     |   |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                                     |   |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                                     |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |   |  |
| 22a. I certify that took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                     |   |   |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                                     |   | TITLE (SPECIFY)<br>Assistant                                |   |   |   | MEDICAL EXAMINER<br>DATE SIGNED 5/7/84                                    |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |                                     |   | ADDRESS<br>111 Penn St. Balto., MD.                         |   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>cremation  |  |                                     | 23b. DATE<br>5/9/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Maryland |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home 1328 Sulphur Spring Rd.  |  |                                     |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>                     |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 4 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruth S. Temple              |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 15 84 |  |  | 2b. HOUR<br>AM  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>8 22 05   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital 21218 |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Librarian                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired  |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |  |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard E. Streaker                             |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Gill   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>578-50-0934  |  | 17 INFORMANT<br>ADDRESS<br>Mr. Lawrence Temple 1515 Round Hill Rd. 21218   |  |   |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) *Myocardial Infarction*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) *ASC D*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

*1 hr*

*5 yrs.*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*Parkinson's*

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/10</i> , 19 <i>77</i> , to <i>5/15</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>8/13</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Franklin E. Leslie</i> DEGREE   |  |  |  | 22c. DATE SIGNED<br><i>5-16-84</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANKLIN E. Leslie  |  |  |  | 22e. ADDRESS<br>3501 48 Paul St Baltimore Md                                   |  |  |  |

|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                   |  | 23b. DATE<br>5/19/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr. 3818 Roland Ave. 21211 |  |                      |  | 25. DATE REC'D. BY REGISTRAR<br>MAY 22 1984 <i>Gina Davidson-Randall</i> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1. FOR  
STATE  
REGISTRAR

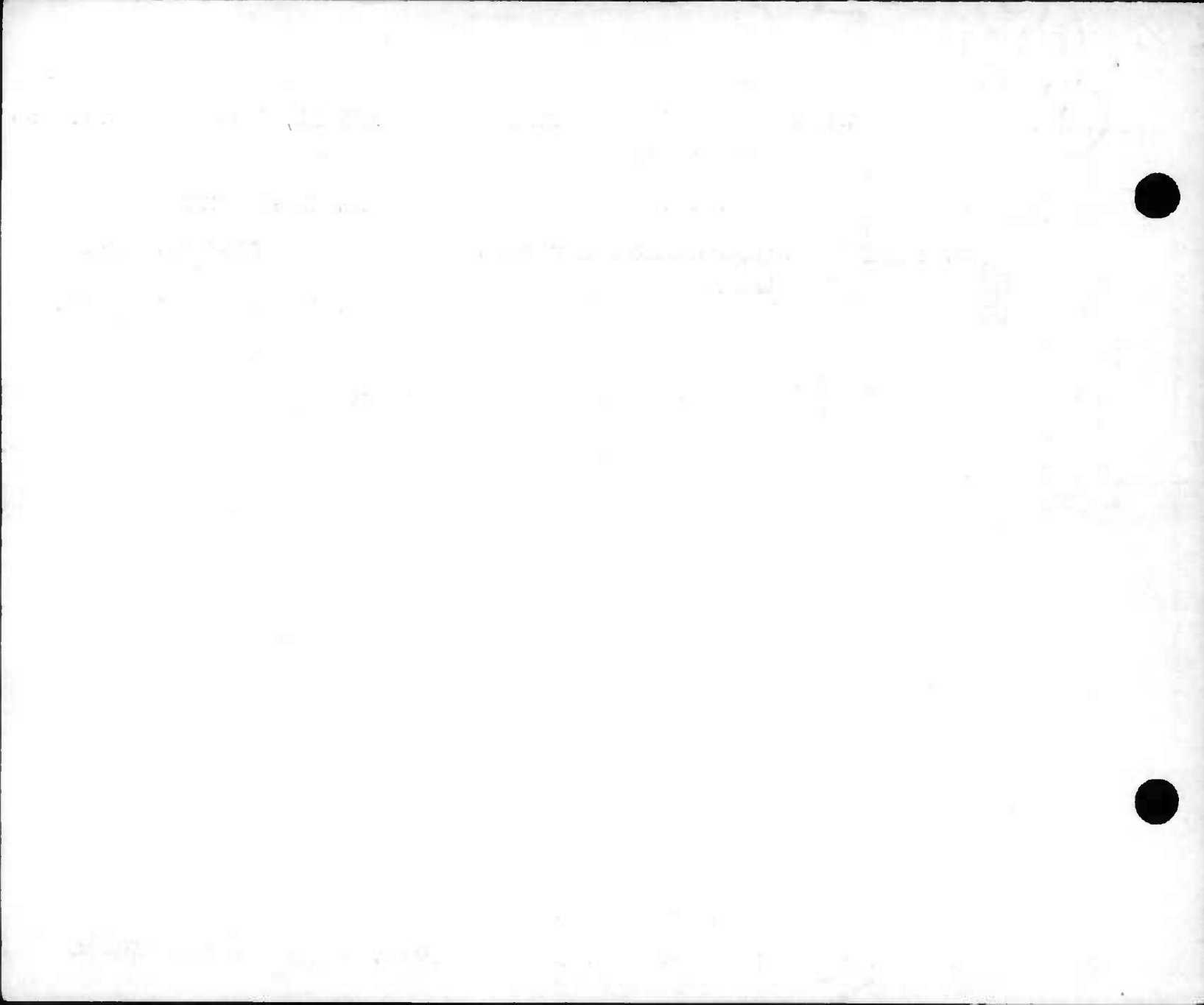
|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LONZY L. TERRY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 21, 1984</b> |   | 2b. HOUR<br><b>01:20am</b>   |  |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 3, 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING TIME)<br><b>FARMER - SELF EMPLOYED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE CITY OR TOWN<br><b>MARYLAND ANNAPOLIS</b>  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>RT. 3 HARNESS CREEK RD. 21403</b>  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DONALD TERRY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLORENCE BRAHAM</b>  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-7360</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>ROSEANN TERRY SAME AS 13C</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) Cardiac arrest</b>  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>25 min</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>Multiple Myeloma, Peritonitis</b>  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/16</b> , 19 <b>84</b> , to <b>5/21</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>George D. Bitter</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/21/84</b>                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Bitter</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hosp Balt MD</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-23-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNAPOLIS ANN ARUNDEL</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS</b>   |  |  |  | 25. DATE REC'D BY REGISTRAR<br><b>MAY 28 1984</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>W. Davidson-Randall</b>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach page 3 to page 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, allow any injury, or other traumatic event, or medical procedure to be marked as such.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 4 9

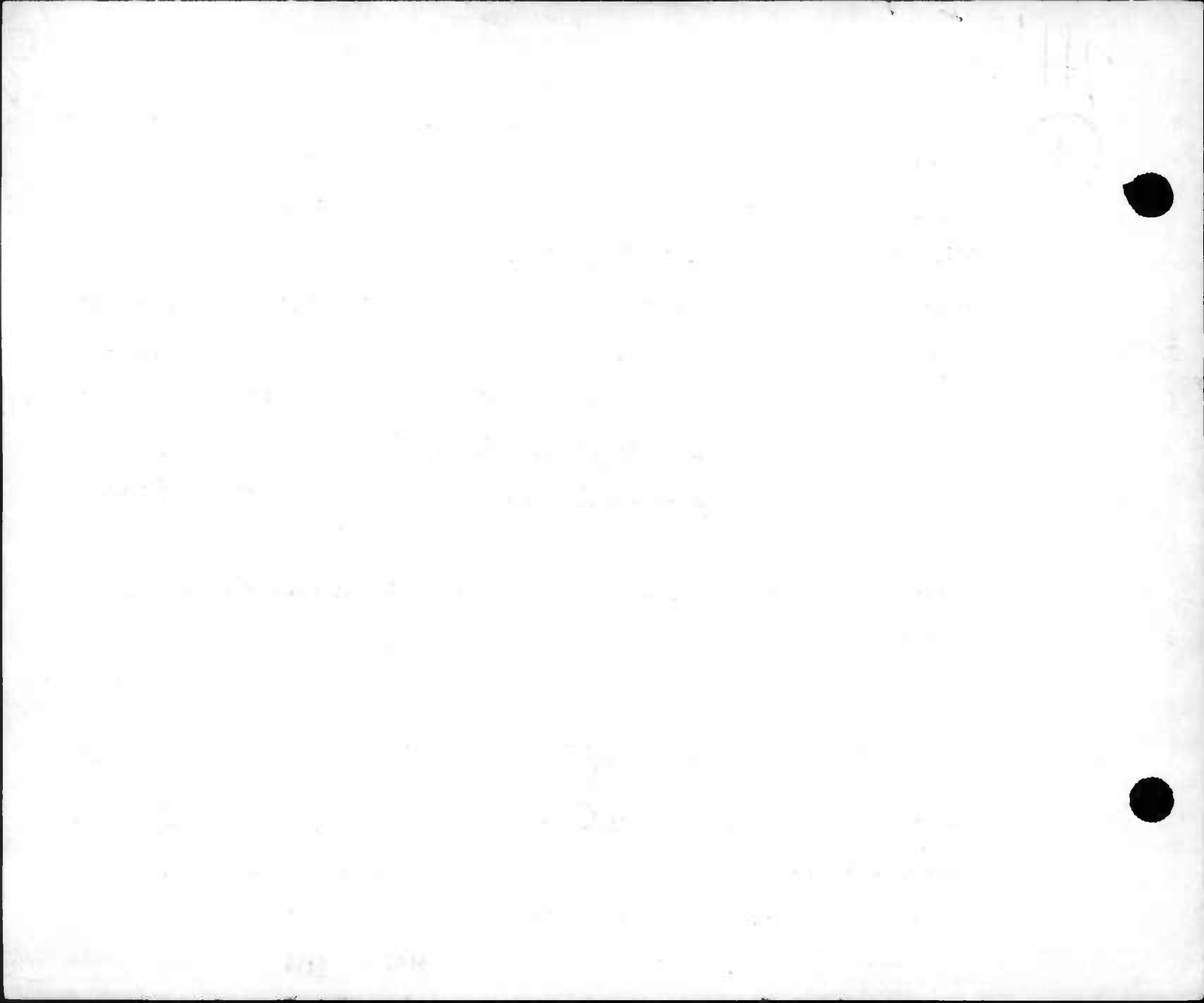
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARK A. TERRY JR.  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 8 84  |  |   |   |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 25 26  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER, BALTO. MD. 21218 |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Mark   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Terry   |  | 13e. STREET ADDRESS / ZIP CODE<br>1716 E. 31st Street 21218   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>219-18-7852   |  | 17. INFORMANT ADDRESS<br>Mark A. Terry III 1802 N. Pulaski St.  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Respiratory Arrest</i><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Squamous Cell Carcinoma of Lung - Mets.</i><br>24RS. DUE TO, OR AS A CONSEQUENCE OF<br>(c)          |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MIN |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Chronic Obstructive Pulm. Disease, Recent Rx of Right Middle Lobe Pneumonia</i>   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><i>none</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (X) (this hospital) attended the deceased from APRIL 28 19 84, to May 8 19 84, that (X) (we) last saw the deceased alive on MAY 8 19 84, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><i>Henry M. Richards MD</i>   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/8/84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HENRY M. RICHARDS MD   |  |   |  | 22e. ADDRESS<br>Balt. VAMC<br>3900 Loch Raven Blvd, Balt MD   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SIC)<br>BURIAL   |  | 23b. DATE<br>5/14/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md National Mem Pl  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Laurel. Md.  |   |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H Inc.  |  |   |  | ADDRESS<br>1101 E North Avenue  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1984   |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a postmortem examination required.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS F THACKER</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>5-19-84</b>  |  |  | 2b. HOUR <b>4.0<sup>PM</sup></b>  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 22, 1929</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hosp. Balto. Md.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RIOL</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>---</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13e. STREET ADDRESS / ZIP CODE <b>1728 Carroll St. Balto. Md. 21230</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Troy Lee Thacker, Sr.</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie --- Cook</b>                            |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |   |  |  | 16b. SOCIAL SECURITY NO. <b>414-34-5742</b>  |  | 17. INFORMANT ADDRESS <b>Balto. Md. 21230</b>                            |   |  |
| 16c. <b>Peace time</b>  |  |   |  |  | 17. <b>Mr. Troy Lee Thacker, Jr. 1251 Washington Blvd.</b>                                   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic malignant melanoma</b><br><b>1729</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Terminal)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Metastasis to Bones L3</b>  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>---</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>---</b>                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>---</b>    |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b> |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>                                    |  |  |   |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>4-24</b> , 19 <b>84</b> , to <b>5-19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  |   | DEGREE <b>MD</b>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>5/19/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANILKUMAR - RAJER</b>  |  |   |  |  | 22e. ADDRESS <b>UMCC</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   | 23b. DATE <b>May 22, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>True Gospel Cemetery</b>                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lisbon Howard Co Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                            |   |  |

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 5 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |  |               |
|---|---|---|---|--|---------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUTH THAXTON</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/15/84</b> |  | 2b. HOUR<br>M |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>NEGRO</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-4-16</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY MD.</b>   |               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. MD.</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>J. H. HOSPITAL</b>  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LIAISON TECH.</b>                     |               |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School System</b>   |   | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1913 E. FEDERAL ST</b> |   |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL AUSTIN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa SAVAGE</b>  |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>578-14-5610A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>JANICE THAXTON 1913 E. FEDERAL</b>  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Death</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Massive Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Heart Disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |   |   |  |               |
| 19a. DATE OF OPERATION<br><b>5-1</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |               |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                               |               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1984</b> to <b>May 15, 1984</b> , that (I) (we) last saw the deceased alive on <b>May 15, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |               |
| 22b. SIGNATURE<br><b>Aldo Paz</b>   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>5-17-84</b>   |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aldo Paz</b>  |   | 22e. ADDRESS<br><b>1000 Cedar St Baltimore Md 21203</b>   |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>5/19/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>   |               |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CITY MD.</b>  |   |   |   |  |               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Locks Funeral Home</b>   |   | ADDRESS<br><b>1304 N. Central Ave</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 18 1984</b>  |               |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Randall</b>   |   |  |               |

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RECEIVED NOTICE OF

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 5 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ZEILMA - THEODORES</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 19 84</b>                                      |  | 2b. HOUR<br><b>11<sup>10</sup> AM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 1, 1915</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                          |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Bus Driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Naquin</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emithiel Thibadeaux</b>                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>463-32-2783</b>   | 17. INFORMANT<br>ADDRESS<br><b>Nelson H. Theodores 3315 Glenmore Ave. 21214</b>            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>4273</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATRIAL FIBRILLATION</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Irving GOTTENED</b>   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/19/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Irving GOTTENED</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>  |   | 23b. DATE<br><b>May 22, 1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Charles H Thiess</b>  |  |   |  |   |  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 9 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>85</b>                                |  | 7b. HOUR<br><b>6:20</b> P. M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>531 N. Robinson St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fire Chief</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City Fire Dept</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>531 N. Robinson St. 21205</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry L. Thiess</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary C. Lephart</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no yes WWI</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-4546</b>  |  | 17. INFORMANT ADDRESS<br><b>Carolyn Tarr (dghtr) same address</b>                               |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes mellitus - ACUP</b>   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 73</b> to <b>5/25</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> 19 <b>84</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Joseph R. Liberto</b>   |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>5/26/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph R Liberto M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>3508 DAVIS ST Balto Md. 21224</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/29/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>                              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Senimunek Funeral Home, Inc.<br/>3331 Brehms Lane, Balto. Md. 21213</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUN 1 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julie Davidson</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |  |  |   |   |  |
|---|--|---|---|---|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Ann</i> FIRST <i>Thomas</i> MIDDLE LAST  |  |   |   |   | 2a. DATE OF DEATH MONTH <i>5</i> DAY <i>12</i> YEAR <i>84</i>            |  |   |   |  | 2b. HOUR <i>7:30 PM</i>                        |   |   |  |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>col.</i>   |   | 5. DATE OF BIRTH MONTH <i>10</i> DAY <i>23</i> YEAR <i>93</i>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.                                    |   |  | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i> |   | IF UNDER 25 HRS<br>HOURS <i></i> MIN. <i></i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.                    |   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Keswick</i> |   |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) <i>HOME MAKER</i>            |   |  | 12b. KIND OF BUSINESS OR INDUSTRY              |   |   |  |
| 13a. STATE <i>MARYLAND</i>  |  |   |   |   | 13b. COUNTY <i></i>  |  | 13c. CITY OR TOWN <i>BALTIMORE</i>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS / ZIP CODE <i>1675 W. NORTH AVE 21217</i> |   |  |
| 14. FATHER'S NAME FIRST <i>THOMAS P.</i> MIDDLE <i>KELSON</i> LAST  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST <i>MARGARET</i> MIDDLE <i>FOWLER</i> LAST |  |   |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  |   |   |   | 16b. SOCIAL SECURITY NO. <i></i>   |  | 17. INFORMANT ADDRESS <i>21228 MRS ALICE CARROLL 5900 OLD FREDERICK RD</i>        |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident, recurrent</i><br><i>4360</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-sclerotic Cerebral Vascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i><br><i>year</i> |  |   |   |   |  |  |   |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  |  |   |   |   |  |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/4</i> 19 <i>72</i> to <i>5-12</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>5-12</i> 19 <i>84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I did) (did not) view the body after death.   |  |   |   |   |  |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE <i>Philip H. Moore</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED <i>5-12-84</i>  |   |   |  |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PHILIP H. MOORE MD</i>   |  |   |   |   |  | 22e. ADDRESS <i>Keswick - 700 W. 40th St</i>                                   |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  |   | 23b. DATE <i>5-16-84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY <i>WESTERN SHARON CATIONVILLE</i>     |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>WATSON CO MD</i> |  |  |   |   |  |
| 24. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i> ADDRESS <i>2222 W. North Ave</i>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1984</i>                               |   |   | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>   |  |   |   |  |

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MAY 28 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

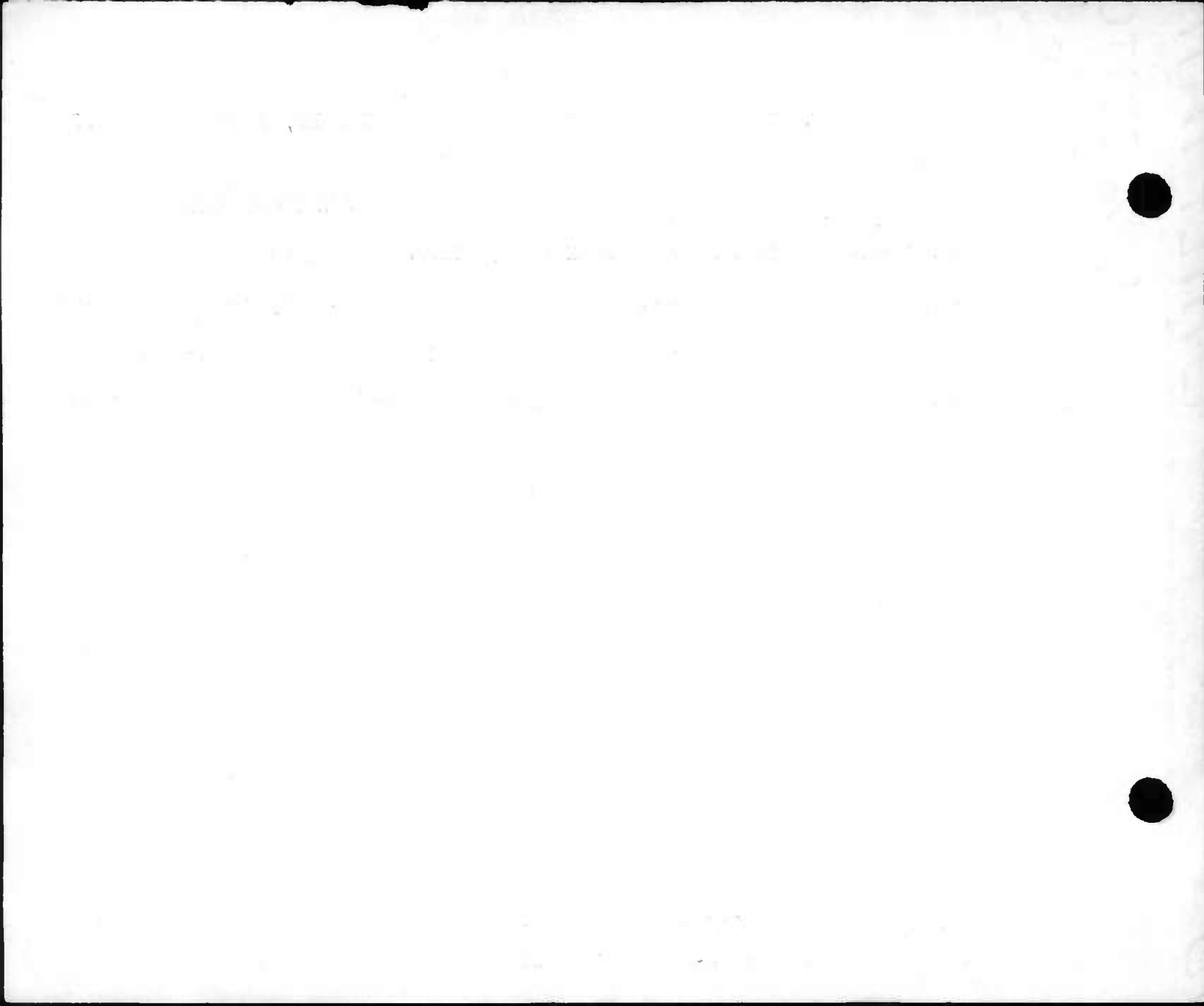
8 4 1 3 4 5 5  
REG. NO.

|  |  |  |  |   |        |   |  |  |   |  |                               |
|--|--|--|--|---|--------|---|--|--|---|--|-------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>BLANCHE</b>   | MIDDLE | LAST<br><b>THOMAS</b>   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 30, 1984</b> |  | 2b. HOUR<br><b>8:35</b>                       |  | A                             |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Blk.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 5 1908</b>   |        | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>75</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>8 35</b> |  | # UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Durham, N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |   |  |                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SHORT-TERM CARE, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |        |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |        |   |  |  |   |  |                               |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1900 Cecil Ave. 21213</b>   |   |  |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ed Shaw</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Drake</b>  |        |   |  |  |   |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>Deborah Harrison 1900 Cecil Avenue</b>   |        |   |  |  |   |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>2989</b> IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pneumonia / Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Dementia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u> |  |  |  |   |        |   |  |  |   |  |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Diabetes, cardiovascular disease</u>  |  |  |  |   |        |   |  |  |   |  |                               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |        |   |  |  |   |  |                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |        |   |  |  |   |  |                               |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>5/30</u> , 19 <u>84</u> , to <u>5/30</u> , 19 <u>84</u> , that (b) (we) lost<br>saw the deceased alive on <u>5/30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (c) (we) (did) (did not) view the body after death.   |  |  |  |   |        |   |  |  |   |  |                               |
| 22b. SIGNATURE<br><u>Stewart Schulman</u>  |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |        |   |  | 22c. DATE SIGNED<br><u>5/31/84</u>   |   |  |                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Stewart Schulman</u>   |  | 22e. ADDRESS<br><u>601 N Broadway Balt Md 21205</u>  |  |   |        |   |  |  |   |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6/2/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |  |   |  |                               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Jas. A. Morton &amp; Sons 1701 Laurens</b>  |  |  |  |   |        | 25a. DATE REC'D. BY REGISTRAR<br><b>June 4 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richardson-Randall</u>  |   |  |                               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner should be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 1 3 4 5 6

1- FOR  
STATE  
REGISTRAR

|   |   |  |  |  |  |                               |  |                            |      |   |  |
|---|---|--|--|--|--|-------------------------------|--|----------------------------|------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE   | LAST   | 2a. DATE OF DEATH  |                               | MONTH  | DAY                        | YEAR | 2b. HOUR  |  |
| Edith Mae Thomas  |   |  |  |  | 5 7 84   |                               |  |                            |      | 6:45 P M  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR               |  | IF UNDER 24 HRS.           |      |   |  |
| Female  | White   | 11 15 1921   |  | 62 YRS   |  | MONTHS                        |  | DAYS                       |      | HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                               |  |                            |      |   |  |
| Maryland  | U.S.A.  |  |  | Baltimore City MD.   |  |                               |  |                            |      |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |                               |  |                            |      |   |  |
| Baltimore   | Baltimore City Hospital   |  | Housewife  |  |  |                               |  |                            |      |   |  |
| 13a. STATE  |   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE                           |                               |  |                            |      |   |  |
| Maryland  |   | Baltimore  | Dundalk  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 505 Trappe Road 21222                                    |                               |  |                            |      |   |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME   |  |  |  |                               |  |                            |      |   |  |
| Daniel Vipperman  |   | Mollie Yowell  |  |  |  |                               |  |                            |      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS                       |  |                            |      |   |  |
| No  |   | 215-14-0510  |  | Shirley A. Miskimon  |  | Same as 13e                   |  |                            |      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:   |   |  |  |  |  |                               |  |                            |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 0389 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest  |   |  |  |  |  |                               |  |                            |      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |  |  |                               |  |                            |      |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |   |  |  |  |  |                               |  |                            |      |   |  |
| (b) Sepsis  |   |  |  |  |  |                               |  |                            |      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |  |  |                               |  |                            |      |   |  |
| (c)   |   |  |  |  |  |                               |  |                            |      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a   |   |  |  |  |  |                               |  |                            |      |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |      |   |  |
|   |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                               |  |                            |      |   |  |
|   |   |  |  |  |  |                               |  |                            |      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN                  |  | COUNTY                     |      | STATE   |  |
|   |   |  |  |  |  |                               |  |                            |      |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from May 7, 19 84, to May 7, 19 84, that (we) last saw the deceased alive on May 7, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |   |  |  |  |  |                               |  |                            |      |   |  |
| 22b. SIGNATURE  |   |  |  |  |  |                               |  |                            |      | DEGREE  |  |
| Robert E. Fisher M.D.   |   |  |  |  |  |                               |  |                            |      | M.D.  |  |
| 22c. DATE SIGNED  |   |  |  |  |  |                               |  |                            |      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)           |  |
| 5/7/84  |   |  |  |  |  |                               |  |                            |      | Robert E. Fisher M.D.                           |  |
| 22e. ADDRESS  |   |  |  |  |  |                               |  |                            |      |   |  |
| 4940 Eastern Ave. Baltimore MD 21224  |   |  |  |  |  |                               |  |                            |      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN |  | COUNTY                     |      | STATE   |  |
| Burial  |   | 5/10/1984  |  | Oak Lawn   |  | Baltimore                     |  |                            |      | Maryland  |  |
| 24. FUNERAL DIRECTOR'S NAME   |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE |      |   |  |
| Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222  |   |  |  |  |  | MAY 10 1984                   |  | John Davidson-Randall      |      |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, or the coroner, must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

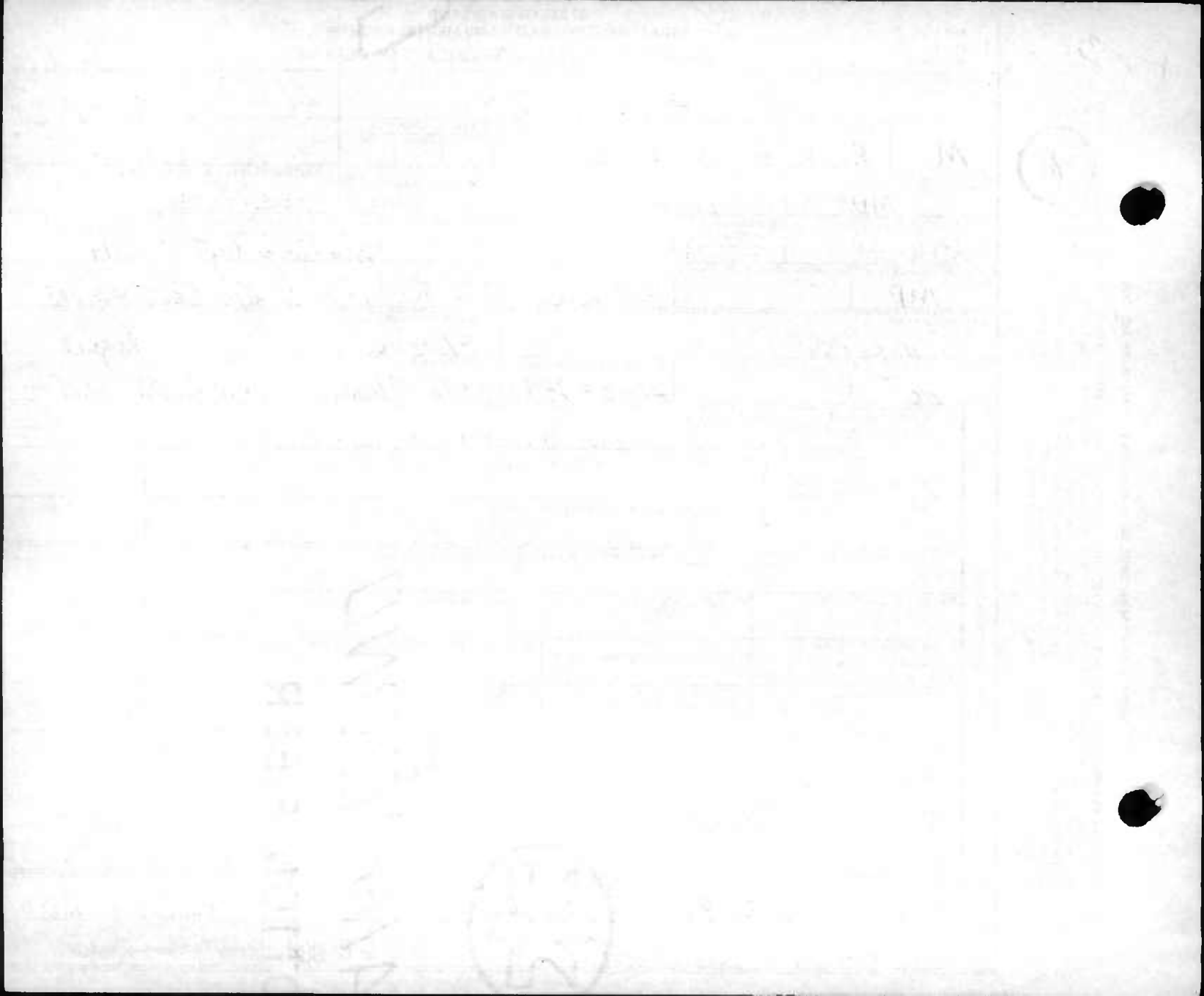
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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 4 5 7

|  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
|--|--|---------|--|--|--|---|--|---|--|---|--|---|--|-------------------|--|---------|--|--|--|
| FOR STATE REGISTRAR  |  |         |  |  |  |   |  |   |  | 1- STATE REGISTRAR                      |  |   |  |                   |  |         |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |  |  |   |  |   |  | FIRST MIDDLE LAST                       |  |   |  |                   |  |         |  |  |  |
| HERBERT  |  |         |  |  |  |   |  |   |  | AVON THOMAS                             |  |   |  |                   |  |         |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                        |  | 7c. DATE KNOWN OF DEATH   |  | 8. MONTH DAY YEAR |  | 9. HOUR |  |  |  |
| M  |  | Black   |  | 6 3 27   |  | 56 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.                              |  | DATE OF DEATH   |  | 5 20 1984         |  | M       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |   |  | 8. MARRIED  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                   |  |         |  |  |  |
| MD.  |  |         |  | USA  |  |   |  | WIDOWED NEVER MARRIED   |  |   |  | Baltimore City MD.  |  |                   |  |         |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                   |  |         |  |  |  |
| Baltimore  |  |         |  | 2409 Linden Ave.   |  |   |  | Sanitation Dept.  |  |   |  | CITY  |  |                   |  |         |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |  |  |   |  |   |  | 13a. STATE                              |  |   |  |                   |  |         |  |  |  |
|  |  |         |  |  |  |   |  |   |  | MD.                                     |  |   |  |                   |  |         |  |  |  |
| 13b. COUNTY  |  |         |  |  |  |   |  |   |  | 13c. CITY OR TOWN                       |  |   |  |                   |  |         |  |  |  |
|  |  |         |  |  |  |   |  |   |  | Baltimore                               |  |   |  |                   |  |         |  |  |  |
| 14. FATHER'S NAME  |  |         |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME                |  |   |  |                   |  |         |  |  |  |
| FIRST MIDDLE LAST  |  |         |  |  |  |   |  |   |  | FIRST MIDDLE LAST                       |  |   |  |                   |  |         |  |  |  |
| UNKNOWN  |  |         |  |  |  |   |  |   |  | Florence Rogers                         |  |   |  |                   |  |         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |         |  |  |  |   |  |   |  | 16b. SOCIAL SECURITY NO.                |  |   |  |                   |  |         |  |  |  |
| NO   |  |         |  |  |  |   |  |   |  | 214-54-7433                             |  |   |  |                   |  |         |  |  |  |
| 17. INFORMANT  |  |         |  |  |  |   |  |   |  | ADDRESS                                 |  |   |  |                   |  |         |  |  |  |
| Edith Thomas   |  |         |  |  |  |   |  |   |  | 1920 Castle Street #13                  |  |   |  |                   |  |         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease   |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| (c)  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| MEDICAL CERTIFICATION  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  | 20. AUTOPSY?  |  |                   |  |         |  |  |  |
|  |  |         |  |  |  |   |  |   |  |   |  | YES NO X  |  |                   |  |         |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  |         |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                   |  |         |  |  |  |
|  |  |         |  |  |  | P.M. 19   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |  |         |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |                   |  |         |  |  |  |
|  |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |  |  |   |  |   |  |   |  |   |  |                   |  |         |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |  |  |   |  |   |  | TITLE (SPECIFY)                         |  |   |  |                   |  |         |  |  |  |
| Ann M. Dixon, M.D.   |  |         |  |  |  |   |  |   |  | M.D. Assistant MEDICAL EXAMINER         |  |   |  |                   |  |         |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |  |  |   |  |   |  | DATE SIGNED                             |  |   |  |                   |  |         |  |  |  |
|  |  |         |  |  |  |   |  |   |  | 5-20-84                                 |  |   |  |                   |  |         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |  |  |   |  |   |  | 23b. DATE                               |  |   |  |                   |  |         |  |  |  |
| Burial   |  |         |  |  |  |   |  |   |  | 5-25-84                                 |  |   |  |                   |  |         |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  |  |  |   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY      |  |   |  |                   |  |         |  |  |  |
| C. Brown   |  |         |  |  |  |   |  |   |  | MT. Zion                                |  |   |  |                   |  |         |  |  |  |
| ADDRESS  |  |         |  |  |  |   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |   |  |                   |  |         |  |  |  |
| 1206 W. North Ave.   |  |         |  |  |  |   |  |   |  | Baltimore, MD.                          |  |   |  |                   |  |         |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR  |  |         |  |  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE              |  |   |  |                   |  |         |  |  |  |
| MAY 28 1984  |  |         |  |  |  |   |  |   |  | Julia Davidson-Randall                  |  |   |  |                   |  |         |  |  |  |

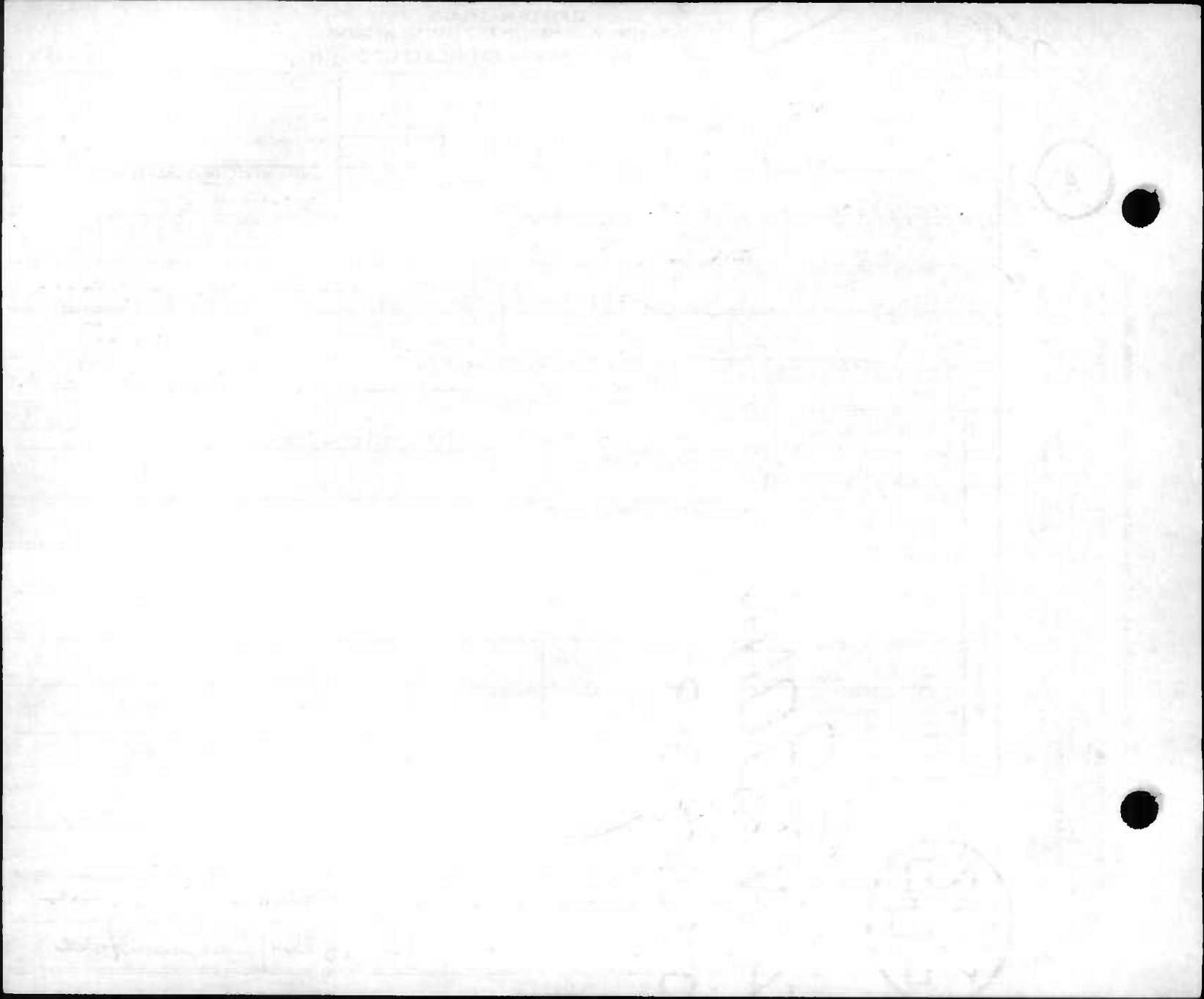


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                  |   |   |   |  |  |   |   |  |  |
|--|------------------|---|---|---|--|--|---|---|--|--|
| FOR Add. Info. Film G591<br>1- STATE REGISTRAR 5/17/84 kam<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4<br>REG. NO. 3 4 5 8  |                  |   |   |   |  |  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JAMES THOMAS JR.   |                  |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>5 14 19 84 |   | 2b. HOUR<br>M<br>12:32  |  |  |
| 3. SEX<br>male   | 4. RACE<br>black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 7 29 1930   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>54 YRS.             | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 14 19 84             |   | 7d. HOUR<br>M<br>12:32  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD            |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>Maryland   |                  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>322 East 22nd St. 21218 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Thomas Sr.   |                  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Thomas  |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Unknown   |                  |   | 16b. SOCIAL SECURITY NO.<br>249-46-5345                     |   | 17. INFORMANT<br>Willie Mae Thomas, 100 Box 572, Elliott, S.C.<br><del>Maggie Boykins 332 East 22nd St. S.C.</del> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |   |   |   |  |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |   |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                      |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |   |   |  |  |   |   |  |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |                  |   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER          |   |  |  |   | DATE SIGNED<br>5-15-84  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |                  |   | ADDRESS<br>111 Penn St., Balto., Md. 21201                  |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL Removal   |                  |   | 23b. DATE<br>5/19/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.<br>Broad Branch  |  | 23d. LOCATION<br>Wisacky, Baltimore, S.C. - Md.   |   |  |  |
| 24. FUNERAL DIRECTOR<br>Marshall P. Hayes, 638 N. Gilmore St. Balto. Md.   |                  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1984                |   | 25b. REGISTRAR'S SIGNATURE<br>Chia Davidson-Randall  |  |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

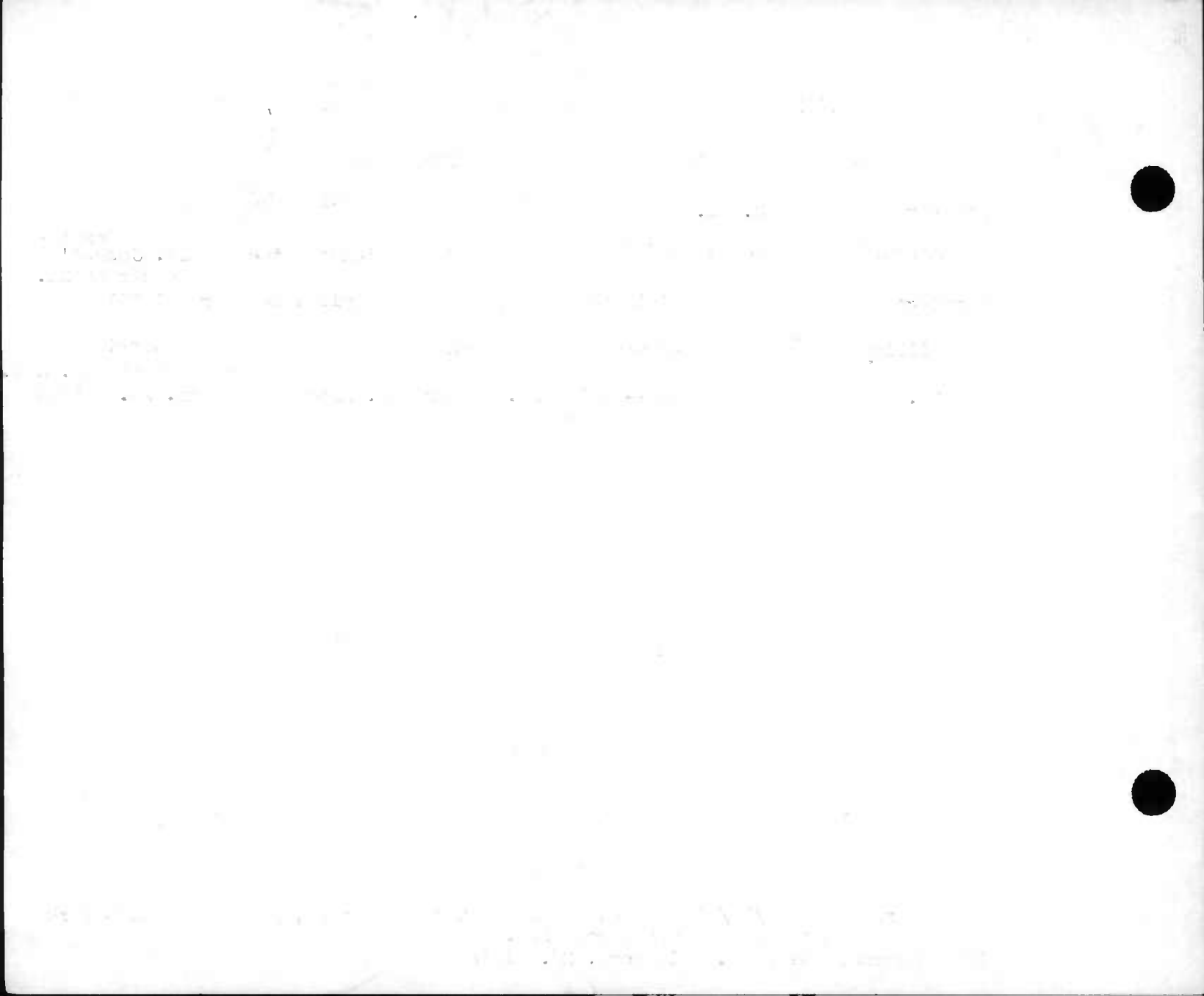
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSIE THOMAS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 10, 1984</b> |   | 2b. HOUR<br><b>8:30</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 5 1930</b>                                   |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietary Aide</b> |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>  |  | 13a. STREET ADDRESS / ZIP CODE<br><b>516 Harper St. Elmira, New York 14901</b>   |  | 13b. CITY OR TOWN<br><b>Elmira</b>  |   |  |
| 13c. COUNTY<br><b>New York</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>516 Harper St. Elmira, New York 14901</b>          |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie Benson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nena Harris</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>      |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>096-22-8872</b>  |  | 17. INFORMANT<br><b>Ms. Victoria D. Brooks</b>   |  | ADDRESS<br><b>4404 Moravia Rd. Apt. 5 Balto. Md. 21206</b>                              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Urinary Tract Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Brain Metastases &amp; Strokes</b>  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 Day</b><br><b>1 Day</b><br><b>3 wks</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5 10 19</b>                       |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12/84</b> , 19 <b>84</b> , to <b>5/10/84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/10/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Jonathan Israel</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/10/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jonathan Israel</b>   |  | 22e. ADDRESS<br><b>600 Wolfe St, Balt, md 21205</b>  |  | 22f. ADDRESS<br><b>600 Wolfe St, Balt, md 21205</b>                                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/14/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                          |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elmira, New York</b>   |  | 23e. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elmira, New York</b>  |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elmira, New York</b>                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                     |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 8 4 1 3 4 6 0  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LEO THOMAS Sr.  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 5, 1984  |   |  | 2b. HOUR<br>8:40A.M.  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 1, 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>79  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital                            |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sanitation       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>508 N. Kenwood Ave. 21205 |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Theodore Thomas   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna -----                                     |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>218-10-3381A   |  | 17. INFORMANT ADDRESS<br>Mary Thomas 508 N. Kenwood Ave.  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC AND RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>POSSIBLE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CARCINOMA OF BLADDER WITH METASTASIS METASTASIS</u> |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>RENAL FAILURE; LEFT BUNDLE BRANCH BLOCK; SWAIN GANZ CATHETERIZATION</u>   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 1, 1984, to MAY 5, 1984, that (I) (we) last saw the deceased alive on MAY 5, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Sompalli Prasad  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>MAY 5, 1984   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SOMPALLI PRASAD, MD.  |  |  |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5-9-1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.                             |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>JOHN M. WEBER & SONS  |  |  |  | ADDRESS<br>401 S. CHESTER ST.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 10 1984                                      |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |

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826-052



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 4 6 1  
REG. NO.1- FOR  
STATE  
REGISTRAR

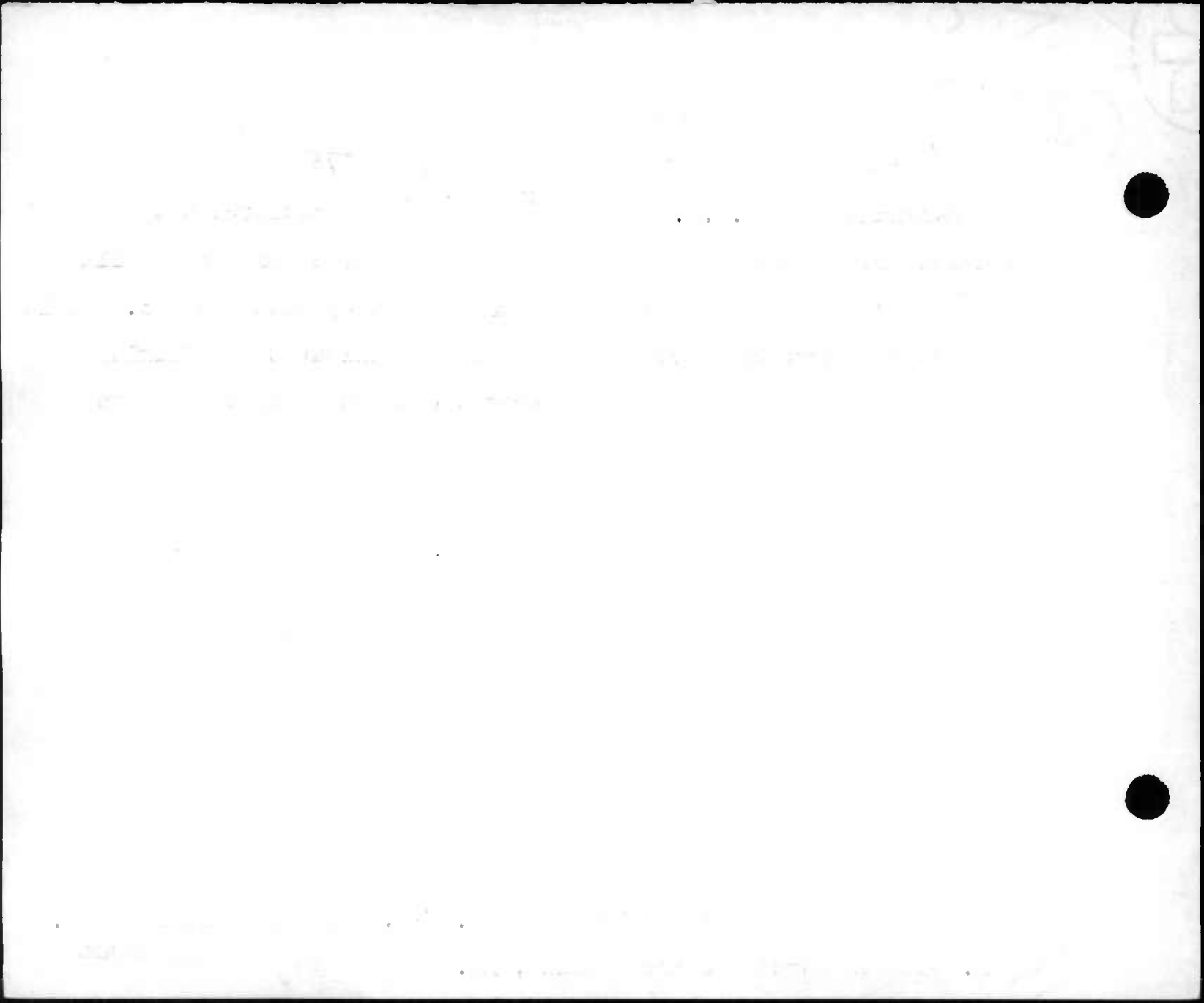
|   |  |  |   |  |   |  |   |   |   |  |
|---|--|--|---|--|---|--|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARTIN Henry Thomas</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/20/84</b>                           |  |   | 2b. HOUR<br><b>425 A</b>   |   |   |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Cau.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 14 69</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |   |   | MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp.</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Milk</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>6503 Glen Oak Ave. 21214</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Martin Luther Thomas</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Elizabeth Blakley</b> |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   |   | 16b. SOCIAL SECURITY NO.<br><b>215-14-9202</b>                    |  |
| 17. INFORMANT<br><b>Jessie Johnson</b>  |  |  | ADDRESS<br><b>same as above</b>   |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292 ASCVD / an. renal failure / DM.</b> |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  | (b)   |  |   | DUE TO, OR AS A CONSEQUENCE OF   |   |   | (c)   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a  |  |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>               |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>M. Mittal</b>  |  |  | DEGREE  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   |   | 22c. DATE SIGNED<br><b>5/20/84</b>                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MITTAL</b>  |  |  | 22e. ADDRESS<br><b>Good Samaritan Hospital</b>                                  |  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>5/22/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Mem. Gar.</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bel Air Harford Md.</b>                        |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>M. Gladden Kurtz</b>   |  |  |   |  |   | ADDRESS<br><b>Jarrettsville, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   |   |  |
|   |  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |   |   |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 13462

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   | 2b. HOUR   |  |
| Alvin Thompson   |  | 5-22-84  |   | M  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR IF UNDER 24 HRS.   |  |
| Male   | Black  | Nov. 12, 1940  | 43  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Maryland   | USA  |  | Balto. City MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore  | 449 E. 22nd St.  |  | Disabled  |  |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       | 13e. STREET ADDRESS                          |
| Md.  |  |  | Balto.  |  | 449 E. 22nd St. 21218                        |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |  |  |
| Charles Thompson   |  | Ruby Buggs   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
|  |  | 213-36-5635  |   | Ruby Thompson 449 E. 22nd St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u>   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4289   |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE</u>   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIAC FAILURE</u>  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |  |  |
| <u>MYOCARDIAL INFARCTION, STROKE</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
|  |  |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 21</u> , 19 <u>84</u> , to <u>MAY 21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MAY 21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| <u>Mr. Keith Rawley</u>  |  | MD   |   | 5/25/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| M. KEITH RAWLEY MD   |  | UNION MEMORIAL HOSPITAL  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  |  |   | Md. Nat. Cem.  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR  |  |
| Brown-Thompson F.H.  |  | 1913 W. Balto St.  |   | MAY 25 1984  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE   |  |
|  |  |  |   | Lia Davidson-Randall   |  |

A

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13463

|  |                  |  |   |   |   |   |                   |   |
|--|------------------|--|---|---|---|---|-------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZABETH THOMPSON  |                  |  | 2a. DATE KNOWN OF DEATH<br>EST. <input checked="" type="checkbox"/> MONTH DAY YEAR<br>MATED <input type="checkbox"/> 5-31-84 19 |   |   | 2b. HOUR<br>M   |                   |   |
| 3. SEX<br>Female   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 3-14 69 YRS.  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>MONTHS DAYS HOURS MIN   | IF UNDER 1 YR   | IF UNDER 24 HRS   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-31-84 19  | 7d. HOUR<br>1:58P |   |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |                  | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |                   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3800 Glenmore Avenue |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Minister                       |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Church   |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 13e. STREET ADDRESS<br>3800 Glenmore Ave  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK Vates  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |   |   |                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |                  |  |   | 16b. SOCIAL SECURITY NO.<br>21720/3824  |   | 17. INFORMANT ADDRESS<br>Hanna Thompson 5907 Redocke Ave.                                       |                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |                  |  |   |   |   |   |                   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |                  |  |   |   |   |   |                   |   |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |                   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |                   |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                  |  |   |   |   |   |                   |   |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |                  |  | TITLE (SPECIFY)<br>Assistant M.D.   |   |   | DATE SIGNED<br>5-31-84  |                   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  |  | ADDRESS<br>111 Penn Street  |   |   |   |                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>6-5-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn City   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |                   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Randolph J. Ledlick  |                  |  |   | ADDRESS<br>2431 E. Oliver St.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 7 1984   |                   |   |
|  |                  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson  |                   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 84 REG. NO. 13464   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAZEL N THOMPSON</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>05 09 84</b>   |  |  |  | 2b. HOUR<br><b>8:30p.m.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-7-99</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>84</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>84</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>city</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hazel Thompson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lettie Thompson</b>   |  |  |  | 16. STREET ADDRESS / ZIP CODE<br><b>827 Arlington Ave. 21217</b>                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>705-12-5447</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ruth Thompson 827 N. Arlington Ave. (17)</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1850</b> IMMEDIATE CAUSE (a) <b>Cancer of prostate with metastasis</b>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>senile dementia</b>   |  |  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Renal failure</b>   |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1a)  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>04/30</b> 19 <b>84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>5/9</b>   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Bon Secour Hosp</b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>04/30</b> , 19 <b>84</b> , to <b>5/9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Kuang-yen Huang MD</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/10/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Bon Secour Hosp</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>5-14-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Balto. MD.</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas.A Rice FSPA 1300 Eutaw Pl.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>                                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 4 1 3 4 6 5  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| ROBERT N. THOMPSON  |  |  |  |  |  |  |  | MAY 2, 1984   |  | 4:45 M                                       |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  | 7. IF UNDER 24 HRS                           |  |
| Male  |  | White  |  | Sept. 4, 1925  |  | 61   |  | MONTHS DAYS   |  | HOURS MIN.                                   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Maryland  |  | USA  |  |  |  | BALTIMORE CITY   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | Sr. Engineer   |  | Western Electric   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | Baltimore  |  | Baltimore  |  |  |  | 231 Dumbarton Rd. - 21212   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |  |  |
| Robert E. Thompson  |  | Mary Jackson   |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |  |  |
| Yes   |  | 220-05-4444  |  | Robert C. Thompson   |  | 8409 Kalk Rd. Richmond, Va. - 23229  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |  | 4 Hrs  |  |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>   |  |  |  |  |  |  |  |   |  |  |  |
| 1539 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |  |
| (b) <u>COLON CARCINOMA</u>  |  |  |  |  |  |  |  |   |  | 2 Yrs  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |  |  |
| (c) _____   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |  |  |
| 9a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 2</u> , 19 <u>84</u> , to <u>MAY 2</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>MAY 2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| <u>Martin Schussberg</u>  |  |  |  |  |  |  |  | 5-2-84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  | 600 N. WOLFE ST. - BALTO. MD.  |  | 21205   |  |  |  |
| <u>Martin Schussberg</u>  |  | <u>John Adams</u>  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Cremation   |  | May 3, 1984  |  | Greenmount   |  | Baltimore City Maryland  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25. DATE RECEIVED BY REGISTRAR   |  |  |  | 25. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  | 6500 York Rd.  |  |  |  | MAL. 1   |  |   |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

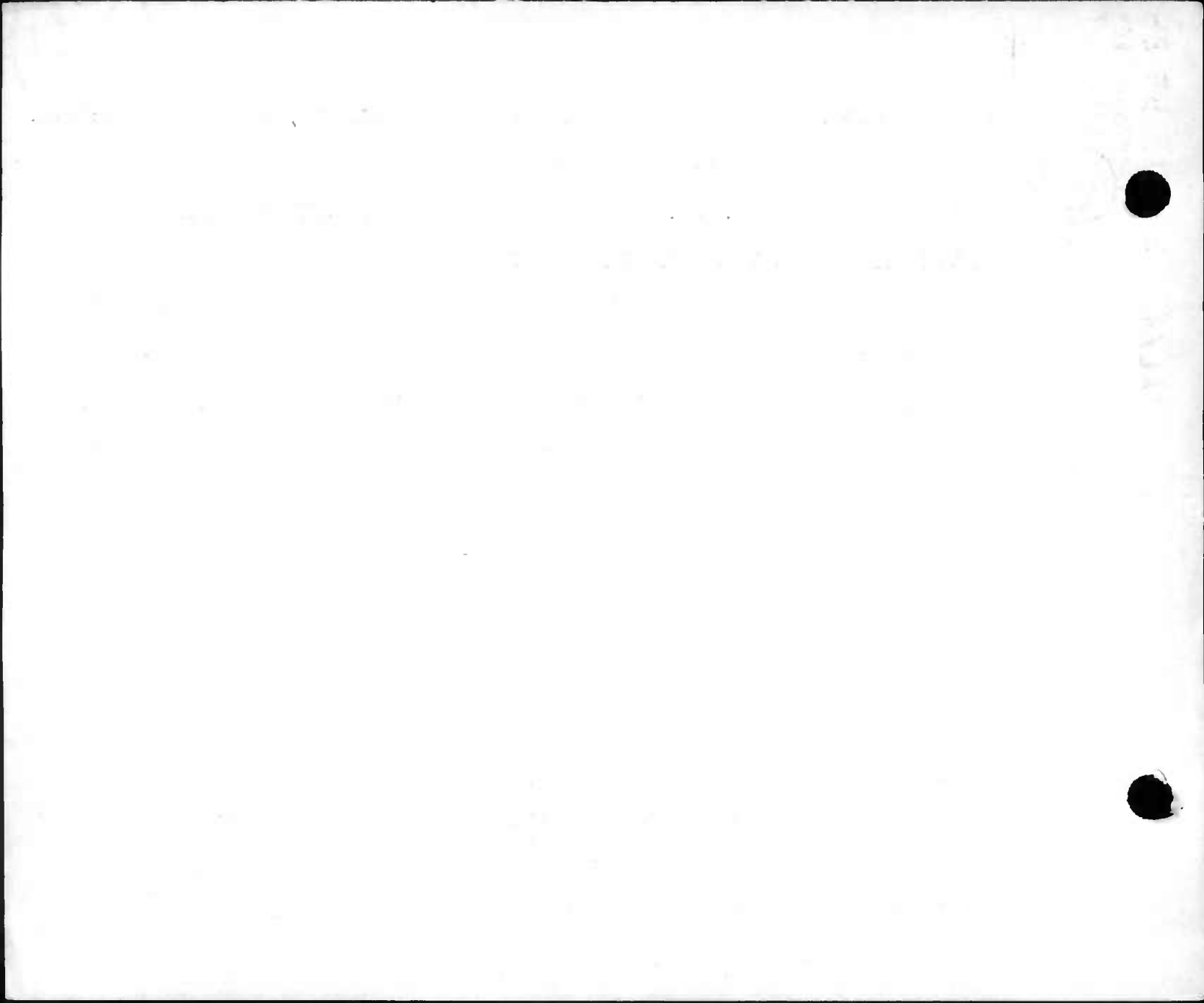
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 6 6

REG. NO.

|  |   |   |  |  |  |   |  |
|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR  |  |
| VERNELL THOMPSON   |   |   |  | MAY 26, 1984   |  | 2:20AM  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| Female   | Black   | 7 1 10  |  | 73 YRS.  |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Virginia   | U.S.A.  |   |  | BALTIMORE CITY MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. BALTIMORE OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| BALTIMORE  | JOHNS HOPKINS HOSPITAL  |   |  |  |  |   |  |
| 13a. STATE   |   | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| Maryland   |   |   |  | Baltimore  |  | 13e. STREET ADDRESS / ZIP CODE<br>2038 E. Preston St. 21213   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 16. ADDRESS  |  |   |  |
| George Robinson  |   | Annie Pryor   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |   |  |
| NO   |   | 215-34-8787   |  | Annie Early 5628 Clearspring Road  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Lung Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____  |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>2 1/2 yrs</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> 19 <u>84</u> to <u>5/26</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/25</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death. |   | 22b. SIGNATURE<br><u>Jonathan Israel</u> MD   |  | 22c. DATE SIGNED<br>5/26/84  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |  |  |   |  |
| Jonathan Israel  |   | North Wolfe St Baltimore Md   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |   | 23b. DATE<br>5/31/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |   | 25. DATE REC'D. BY REGISTRAR  |  | 25. REGISTRAR'S SIGNATURE  |  |   |  |
| Wm C March F/H Inc. 1101 E North Avenue  |   | MAY 29 1984   |  | Julia Davidson-Randall   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8413467  
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>VERNON C THOMPSON  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>05 16 84  |  | 2b. HOUR<br>6:25 AM  |  |
| 2. SEX<br>M   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 30 45  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>39 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>MD.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>URBAN Agency  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOSHUA PURDI   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELEASE THOMPSON   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>214-40-1978  |  |
| 17. INFORMANT<br>Kleese Thompson  |  | 17. ADDRESS<br>1517 N. GILMORE  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Non-Oat Cell Carcinoma Lung |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF (b)  |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15/84 to 5/16/84, that (I) (we) last saw the deceased alive on 5/16/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Mary Carroll MD   |  | DEGREE  |  | 22c. DATE SIGNED<br>3/16/84   |  | 22d. ADDRESS<br>201 ST. PAUL ST. BALTO. MD.  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. CARROLL   |  | 22f. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5-21-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Kendalltown Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JAS. A. MORTON & SONS   |  | ADDRESS<br>1701 LAURENS   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 18 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

90% COTTON L

CHIEFMAN

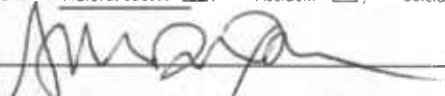
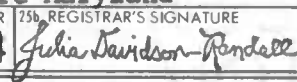


MADE IN CHINA

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |   |   |  |   |   | REG. NO. 3 4 6 8                             |  |
|--|-------------------------|--|---|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WALLACE C. THOMPSON</b>   |                         |  |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 3 19 84</b> |   | 2b. HOUR<br>M <b>AM</b>   |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 28, 1912</b>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>71</b> YRS.           | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 8 19 84</b>                                     |  | 2d. HOUR<br>P.M. <b>12:26</b>                       |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> M.D.                              |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>201 N. Broadway</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>201 N. Broadway 21231</b> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late Alton Thompson</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Queenie Moran</b>  |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212 18 3785</b>   |   | 17. INFORMANT ADDRESS<br><b>M's Norma Simpson 3121 Mayfair Rd Balto. 21207</b>  |   |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) Carcinoma of lung</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |  |   |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |   |   |   |  |   | DATE SIGNED<br><b>5-8-84</b>  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>           |   |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>May 11, 1984</b>                            |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke</b>  |                         |  |   |   | ADDRESS<br><b>4112 Columbia Rd Ellicott City</b>                              |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br> |  |  |

Police July 20, 1942 VI

Police, Md. U.S.A.

Received

101 N. Broadway 11131 Maryland California

late Alton Thompson late Quentin Moran

2120V

212 26 0702 M's Norma Simpson 1121 Maryland Md Police.

Harry H. Wicks 4111 Columbia Rd. Ellicott City  
May 11, 1944 London Park  
Baltimore Maryland



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 4 6 9

FOR  
1- STATE  
REGISTRAR

|  |  |                  |                 |   |  |   |  |   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
|--|--|------------------|-----------------|---|--|---|--|---|-----------|---|--|---|--|---|---|--|--|---|--|--|-----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Thomas |   |  | MIDDLE<br>Thorne  |  |   | LAST<br>E |   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED                     |  |   | <input checked="" type="checkbox"/> MONTH<br>DAY<br>5 |  |  | YEAR<br>79 84                                   |  |  | 2b. HOUR<br>M<br>9:40 |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 3 19   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>64 YRS.                     |  | IF UNDER 1 YR.<br>MONTHS DAYS   |           | IF UNDER 24 HRS.<br>HOURS MIN.                                  |  | 2c. DATE<br>PRONOUNCED<br>DEAD                              |  |   | MONTH DAY YEAR<br>5 7 84                              |  |  | 2d. HOUR<br>M<br>9:40                           |  |  |                       |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>NORTH CAROLINA   |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |           |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |   |   |  |  |   |  |  |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Elain & Pulaski Streets |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>RETIRED   |           |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                        |  |   |   |  |  |   |  |  |                       |  |  |
| 13a. STATE<br>MARYLAND   |  |                  |                 | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |           | 13e. STREET ADDRESS<br>2209 N. PULASKI ST. 21217                |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH THORNE  |  |                  |                 |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PENINA CLARK     |  |   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |                  |                 | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br>CAROLYN KELLY 3833 JANBROOK RD. 21133 |  |   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound to chest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |                 |   |  |   |  |   |           |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |                       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                  |                 |   |  |   |  |   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |           |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |   |  |  |                       |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:25 5 7 1984  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  |                  |                 | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>street  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2200 Blk. Pulaski St, Balto., MD.  |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |                 |   |  |   |  |   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| ACTUAL<br>SIGNATURE<br>Dennis F. Smyth, M.D.   |  |                  |                 | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |   |  |   |           |   |  |   |  | DATE<br>SIGNED<br>5/7/84  |   |  |  |   |  |  |                       |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |                 | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |   |           |   |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |                  |                 | 23b. DATE<br>5-11-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST VET.        |  |   |           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GARRISON MARYLAND |  |   |  |   |   |  |  |   |  |  |                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.J. PHILLIPS  |  |                  |                 | ADDRESS<br>1721 N. MONROE ST.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984   |           |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall        |  |   |   |  |  |   |  |  |                       |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

PTA 12-10-1961

4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3J should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 84 13470  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Wilson J Thornton Sr.</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>5 15 84</b>  |  | 2b. HOUR <b>2:50 PM</b>  |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>N 2</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>01 03 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. STREET ADDRESS  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Luther Thornton</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Sharp</b>   |  | 1506 N. Port St. 21213   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>213-09-1173</b>  |  | 17. INFORMANT ADDRESS <b>Veronica Thornton 1506 N. Port St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>respiratory failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Myocardial infarction, Multiple cerebrovascular accidents</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> , 19 <b>84</b> , to <b>5/15</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Don St. Martin</b> DEGREE <b>MD</b>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>5/15/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Don St. Martin</b>  |  |  |  | 22e. ADDRESS <b>Mercy Hospital Balt</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |  | 23b. DATE <b>5/19/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March Funeral Home</b> ADDRESS <b>1101 E North Ave</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Sha Davidson-Randall</b>   |  |

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JAN 10 1900  
U.S. DEPT. OF AGRICULTURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

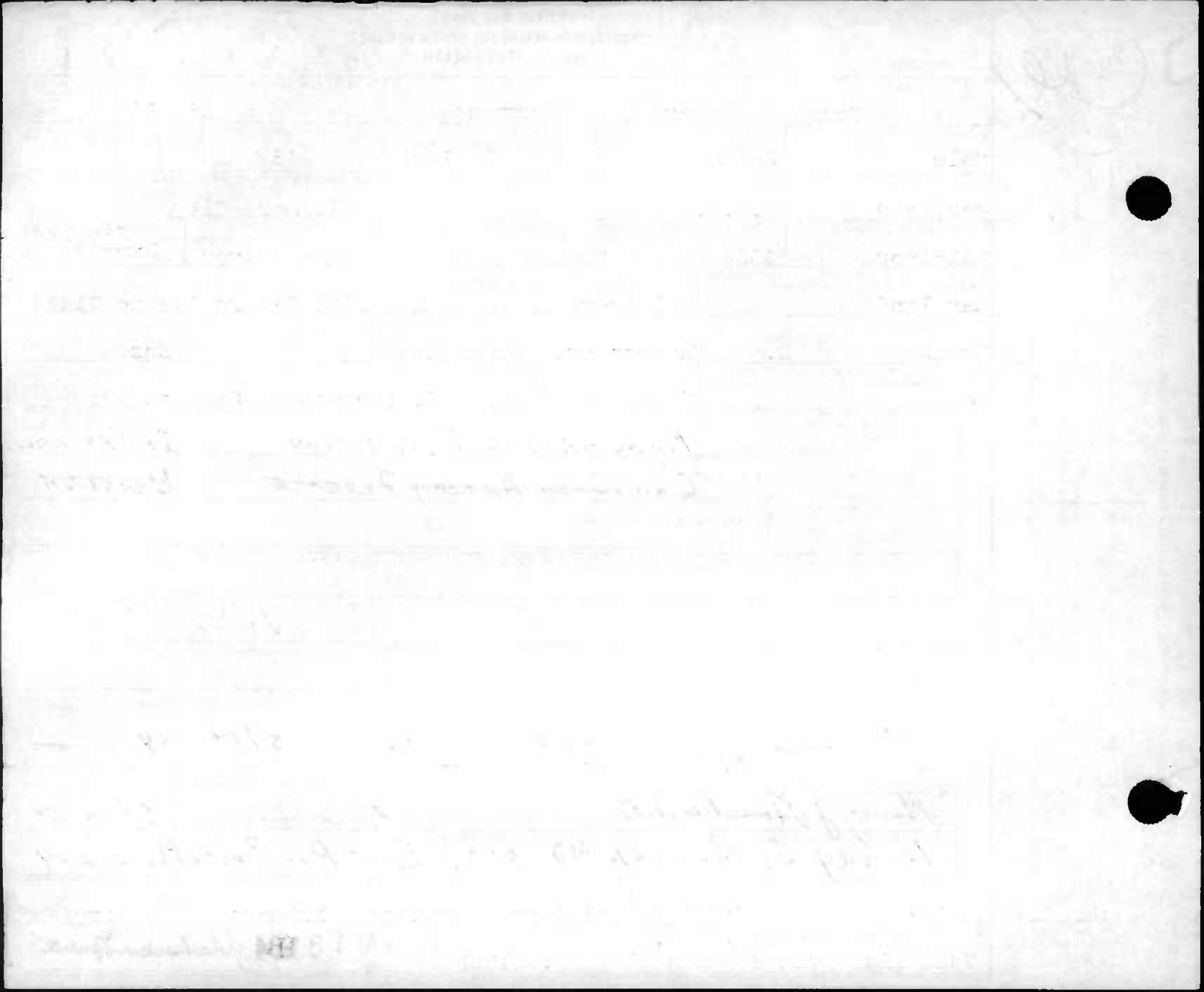
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 REG. NO. 13471

|   |  |   |   |  |                            |  |
|---|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frank Howard Thurman</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 14 84</b> |  | 2b. HOUR<br>M<br><b>AM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 7 1937</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |   | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3324 Elmora Avenue</b> |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sieglers Express</b>  |   | 13a. STREET ADDRESS / ZIP CODE<br><b>3324 Elmora Avenue 21213</b>  |                            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank H. Thurman, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta Busch</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                           |                            |  |
| 17. SOCIAL SECURITY NO.<br><b>215-34-8769</b>   |  | 18. INFORMANT<br><b>Donna J. Thurman</b>  |   | 19. ADDRESS<br><b>Same as 13e</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNKNOWN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>4/2</b> 19 <b>76</b> to <b>5/14</b> 19 <b>84</b> , that (I) (we) (lost) saw the deceased alive on <b>5/11</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |                            |  |
| 22b. SIGNATURE<br><b>Henry J. Houska MD</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>5/16/84</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HENRY J. HOUSKA MD</b>  |  | 22e. ADDRESS<br><b>333 S. EAST AVE BALTO MD 21224</b>   |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/17/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>  |   |  |                            |  |
| 25a. DATE RECD. BY REGISTRAR<br><b>MAY 18 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Anderson-Randall</b>  |   |  |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 10 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 84 REG. NO. 13472                            |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILNERO J TILGHMAN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 30 84 |   |  | 2b. HOUR<br>1140A   |  |  |  |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>N  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 1 20  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY BALTIMORE MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5130 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1742 Normal Avenue 21213   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Smith   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline Pratt   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unknown   |  | 16b. SOCIAL SECURITY NO.<br>218-16-3256   |  | 17. INFORMANT ADDRESS<br>James E. Tilghman 1742 Normal Avenue   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MULTIPLE Myeloma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/9/84</u> , 19 <u>84</u> , to <u>5/30</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>5/30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>M. McCarthy</u>  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>5/30/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. McCarthy</u>   |  |   |  | 22e. ADDRESS<br><u>South Baltimore Gen Hosp</u>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>6/4/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>BALTIMORE, COUNTY MD. STATE  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc, 1101 E North Avenue   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 4 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |  |  |

IBES

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CHANGE

100% for the future



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IMPORTANT: If item 21 is marked as item 8 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |  |  |  |
|---|--|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | 84 REG. NO. 13473                                 |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BARBARA K. TILL   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 21 84       |  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>03 16 14   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS  |  | 2b. HOUR<br>8 <sup>10</sup> A.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (PRINT IN FULL EACH FIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>---   |   | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2803 DELMONT AVENUE, 21230  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ALBERT KUHL  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SADIE STABB           |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>215-05-6480  |   | 17. INFORMANT ADDRESS<br>JACOB TILL 2803 DELMONT AVENUE, 21230  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Adeno Carcinoma of Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Emphysema</u>  |  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br>5/21  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10 19 84 to 5/21 19 84, that (I) (we) last saw the deceased alive on 5/21 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.  |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br>Victor S. Roth  |  |  | DEGREE<br>M.D.  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5/23/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VICTOR S. ROTH M.D.  |  |  | 22e. ADDRESS<br>700 Washington Blvd, Balto 21230                    |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>05-24-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND |  |  |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.   |  |  | ADDRESS<br>4107 WILKENS AVE. 21229                                  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pandey  |  |

BP



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 13474

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST George MIDDLE Roosevelt LAST Toliver Jr.  
George R. Toliver Jr.

2a. DATE OF DEATH MONTH DAY YEAR 5-15-84 2b. HOUR 0835 M

3. SEX

M

4. RACE

B

5. DATE OF BIRTH

MONTH DAY YEAR 04 21 28

6. AGE (IN YEARS LAST BIRTHDAY)

56 YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Magnolia, Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

MEMSS

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Truck Driver

12b. KIND OF BUSINESS OR INDUSTRY

Industrial

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD.

13b. CITY OR TOWN XXXXXXXX

13c. CITY OR TOWN Joppa

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

411 Pulaski Highway 21085

14. FATHER'S NAME

FIRST George

MIDDLE Roosevelt

LAST Toliver, Sr.

15. MOTHER'S MAIDEN NAME

FIRST Eva

MIDDLE Viola

LAST Stevenson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

WWII

17. INFORMANT

214-20-2134

17. INFORMANT

Mrs. Edith C. Toliver, 411 Pulaski Hwy, Joppa, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

8162

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Multiple injuries with complications

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

motorcycle accident

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 5:05 PM 4-26-1984

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Operator of motorcycle that lost control.

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) road

21f. LOCATION

STREET

Rt. 40 & Joppa Farm Rd.

CITY OR TOWN

COUNTY

STATE

Harford Md.

22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 5/15/84, 1984, and that in (my) (our) opinion death occurred on 5/15/84, 1984, and from the causes stated.

22b. SIGNATURE

Suzanne Wedel

DEGREE

22c. DATE SIGNED 5/15/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

S. Wedel

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

May 18, 1984

23c. NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens, Bel Air

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Harford Md.

24. FUNERAL DIRECTOR

Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAY 17 1984

John Davidson-Randall



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 REG. NO. 13475

|  |  |  |  |   |  |  |                                   |  |
|--|--|--|--|---|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROBERT H. TOWSON</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 3, 1984</b> |   | 2b. HOUR<br><b>M</b>   |  |                                   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 17 13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.              |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1734 EAST PRESTON STREET</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Towson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella</b>  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-7016</b>   |  | 17. INFORMANT ADDRESS<br><b>Elizabeth Jones 2634 Beryl Avenue</b>   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CANCER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19 1984</b> to <b>MAY 3 1984</b> , that (I) (we) last saw the deceased alive on <b>April 21 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |                                   |  |
| 22b. SIGNATURE<br><b>Winthrop C. Davis, MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/3/84</b>  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Winthrop C. Davis, MD</b>  |  |  |  | 22e. ADDRESS<br><b>700 WASHINGTON BLVD., BALT., MD.</b>   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/7/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>4 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wm C March</b>  |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 8413476                             |  |  |  |  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GWENDOLYN TRIPP   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/14/84   |  |  | 2b. HOUR<br>3:40 PM                            |  |  |  |  |  |  |   |  |   |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2/23/02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |  |  |  |  |   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>BALTIMORE   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |  |  |  |  |  |   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>701 ARKINGTON AVE 21217 |  |  |  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SAMUEL JOHNSON  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>RACHEL DORSEY   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>218-01-5775   |  | 17. INFORMANT ADDRESS<br>GWENDOLYN Fields 1701 EULAN ST.  |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 2030 CARDIO RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF SEPSIS<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF MULTIPLE MYELOMA<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |   |  |  |  |
| MEDICAL CERTIFICATION  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
|  |  |   |  |   |  |   |  |  |  |  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|  |  |   |  |   |  |   |  |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
|  |  |   |  |   |  |   |  |  |  |  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/11/84 to 4/14/84, that (I) (we) last saw the deceased alive on 4/14/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>L. CUETO   |  |   |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/14/84                  |  |  |  |  |  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. CUETO  |  |   |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5/19/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cribitus Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cribitus, Maryland                                |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>The Bailey General Home   |  |   |  | ADDRESS<br>1348 N. Calhoun  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 17 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |  |  |  |  |   |  |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

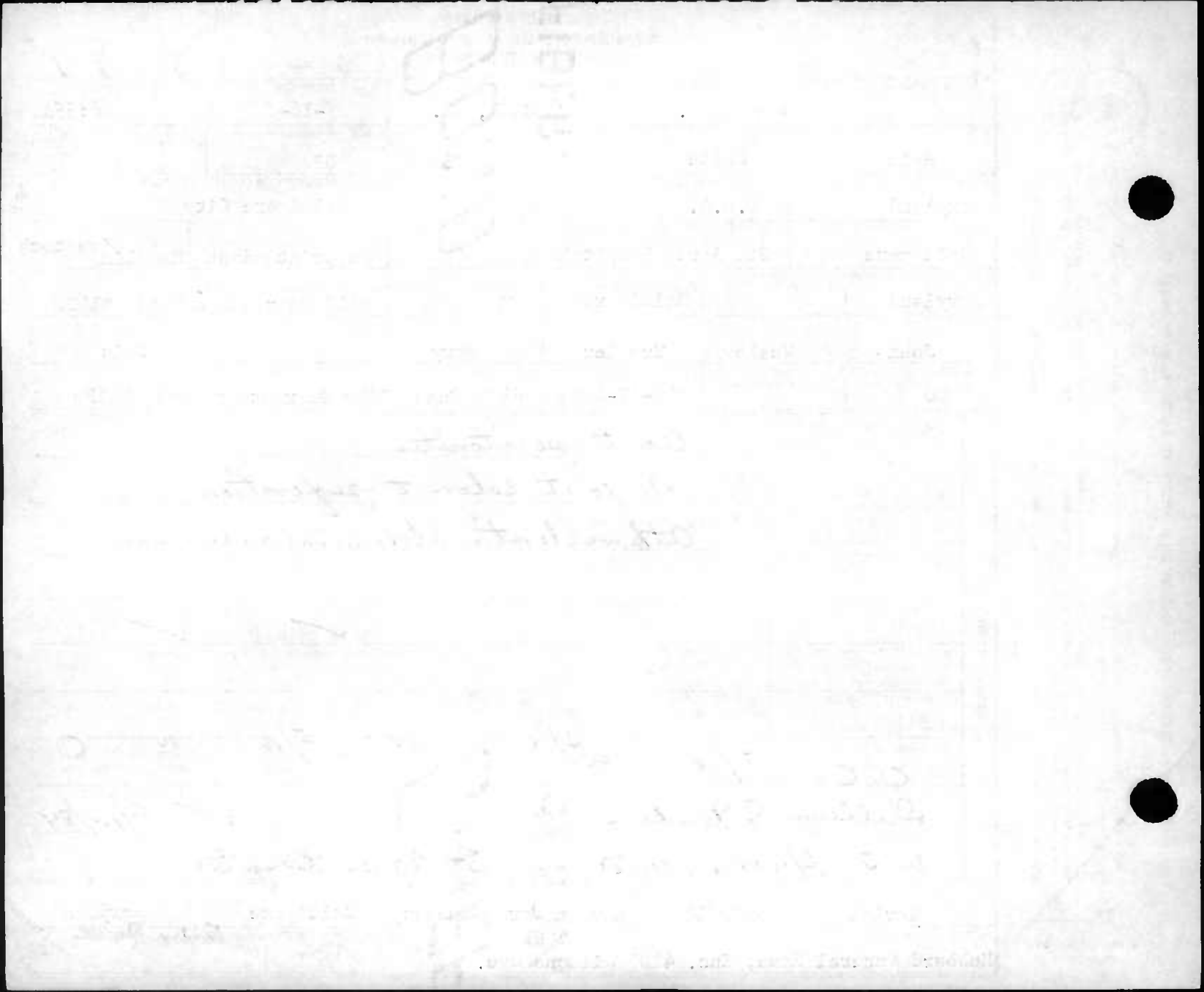
REG. NO. 8413477

|   |  |   |  |   |  |  |  |  |                                    |  |  |
|---|--|---|--|---|--|--|--|--|------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DAVID F. TROGLER, SR.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-16-84                         |   | 2b. HOUR<br>6:55A <sub>M</sub>   |  |  |  |                                    |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 6 1900  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD        |  |  |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Superintendent   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Livestock Handling  |  |                                    |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                                    | 13e. STREET ADDRESS / ZIP CODE<br>2619 Georgetown Road 21230 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Wesley Trogler   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Chic             |   |  |  |  |  |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-07-4434 |   | 17. INFORMANT<br>ADDRESS<br>Doris Szech 2619 Georgetown Road 21230                   |  |  |  |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute peritonitis</u><br>4414<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Infant colon perforation</u><br>(c) <u>Atherosclerotic abdominal aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>  |  |   |  |   |  |  |  |  |                                    |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> 19 <u>84</u> to <u>5/16</u> 19 <u>84</u> , that (I) <u>we</u> last saw the deceased alive on <u>5/16</u> 19 <u>84</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.  |  |   |  |   |  |  |  |  |                                    |  |  |
| 22b. SIGNATURE<br><u>William J. Hicken</u>  |  |   |  | DEGREE<br><u>MD</u>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>5/16/84</u> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>W. J. HICKEN, M.D.</u>  |  |   |  | 22e. ADDRESS<br><u>St Agnes Hospital</u>  |  |  |  |  |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/19/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  |   |  | 24b. ADDRESS<br>21229<br>4107 Wilkens Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 18 1984                     |  | 25b. RECORDING OFFICER<br><u>Thomas R. Riddle</u>                  |                                    |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page empty be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |                              |  |  |
|--|--|---|--|---|---|---|------------------------------|--|--|
| 1. FOR REGISTRAR   |  | 8 4 1 3 4 7 8<br>REG. NO.   |  |   |   |   |                              |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES A. TROTMAN</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 23 1984</b> |   | 2b. HOUR<br><b>1:45 A.M.</b> |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 30 98</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                               |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS<br><b>4202 Evans Chapel Rd. 21211</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Trotman</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Butts</b>  |   |   |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-9154</b>  |  | 17. INFORMANT ADDRESS<br><b>Lillian B. Trotman 3600 Dennlyn Road</b>  |   |   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE COLON WITH LIVER METASTASES</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>LIVER METASTASES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b> |  |   |  |   |   |   |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS</b>  |  |   |  |   |   |   |                              |  |  |
| 19a. DATE OF OPERATION<br><b>2 9</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 19 19 84</b> to <b>MAY 23 19 84</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 23 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>C. VERGARA-SOARES</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |   |   |                              | 22c. DATE SIGNED<br><b>5-23-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. VERGARA-SOARES</b>  |  |   |  | 22e. ADDRESS<br><b>N. CHARLES GEN. HOSP. BALT. MD. 21208</b>  |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/25/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus MemorialPk</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>                               |                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>   |  |   |  | ADDRESS<br><b>1101 E North Avenue</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

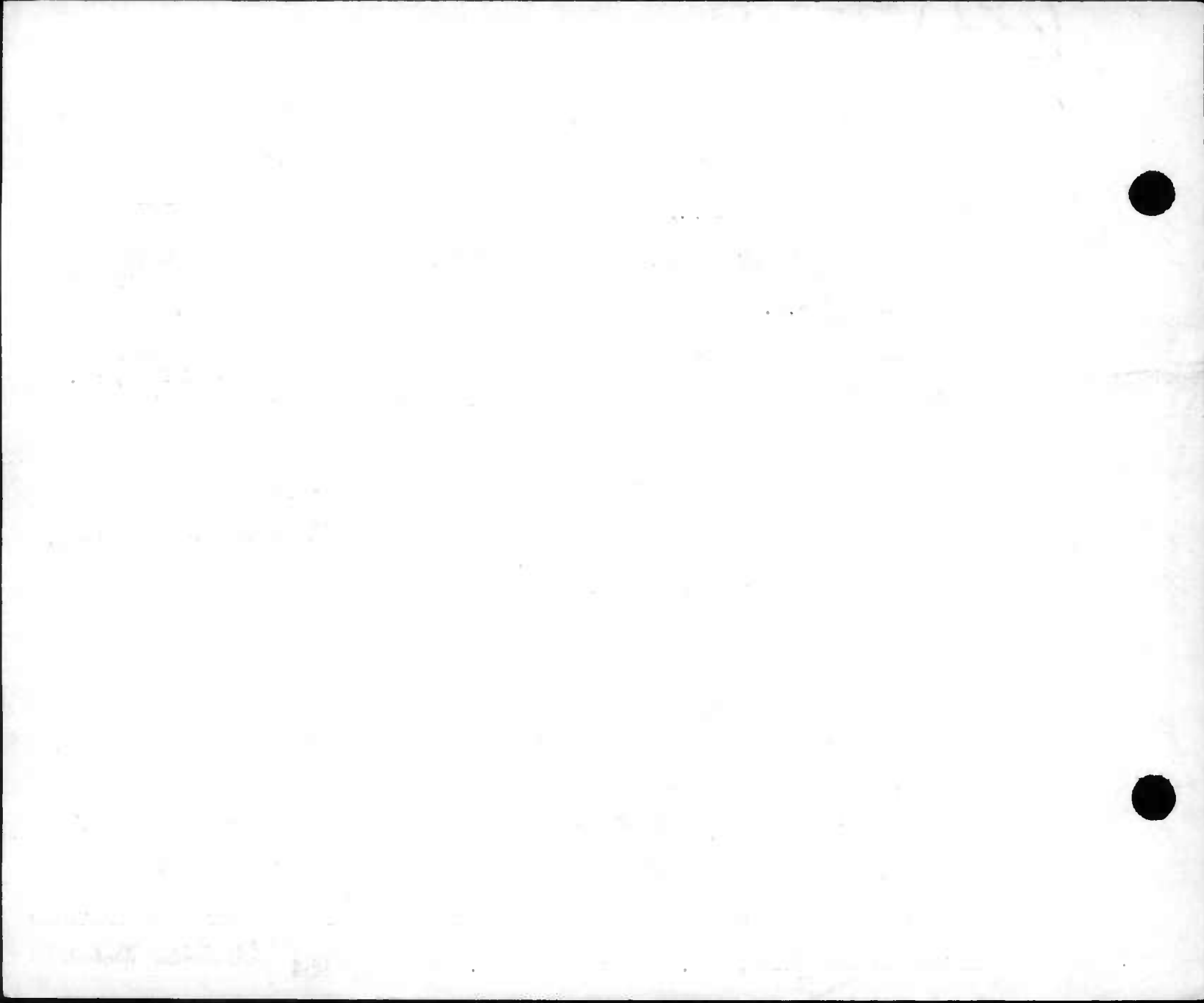
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8413479  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                    |  |
|--|--|---|---|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES THOMAS TURLINGTON   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/5/84 |  | 2b. HOUR<br>2301 M |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 10 06   |                    |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |                    |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |  |
| 12. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSPITAL |   | 14. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |                    |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br>MARYLAND  |  | 15b. COUNTY<br>A.A.   |   | 15c. CITY OR TOWN<br>LINTHICUM   |                    |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ARTHUR TURLINGTON  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FANNIE BAYLEY  |   | 18. STREET ADDRESS / ZIP CODE<br>500 ANDOVER ROAD, 21090   |                    |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, AND/OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 20. SOCIAL SECURITY NO<br>216-09-1342   |   | 21. INFORMANT<br>ADDRESS<br>VIRGIE NAOMI TURLINGTON 500 ANDOVER ROAD   |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4310 IMMEDIATE CAUSE (a) <u>CARDIO-RESPI. ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PERIOTIC INFECTION</u> with<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>Secondary massive intracerebral hemorrhage</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Generalized arteriosclerosis</u> |  |   |   |  |                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from 5/4/84, 19 84, to 5/5/84, 19 84, that (I) (we) last saw the deceased alive on 5/5/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |   |   |  |                    |  |
| 22b. SIGNATURE<br>Walter Lockhart, M.D.  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |   | 22c. DATE SIGNED<br>5/5/84   |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER LOCKHART   |  | 22e. ADDRESS<br>SOUTH BALTIMORE GEN HOSP  |   |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>05-09-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN CEMETERY  |                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN BALTIMORE MARYLAND  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229  |   |  |                    |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |  |                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3, and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 REG. NO. 1 3 4 8 0

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ada TATT</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 18 84</b>   |  | 2b. HOUR<br><b>230 AM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 1 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>79</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unknown</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cherry Point Marine Base</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore,</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Allen Thompson</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillie Mc Carthy</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>246-20-0333</b>  |  |
| 17. INFORMANT ADDRESS<br><b>3004 Chelsea Terrace Baltimore, Maryland 21216</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Unknown (presumed cardiopulmonary arrest)</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Unknown</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/18/84</b> , 19____, to <b>5/18/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>Never</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert W. Herring</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>5/18/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert W. Herring</b>  |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/26/1984</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Broad Creek</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Kingston, N. C.</b>   |  | 24. FUNERAL DIRECTOR NAME<br><b>Nutter &amp; Sons Funeral Home Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1984</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  | 25c. ADDRESS<br><b>2501 Gwynns Falls Pkwy, Baltimore, Md. 21216</b>   |  | 25d. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |

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Cherry

2501 Gaymans Falls Hwy, Baltimore, Md. 21215  
Walter & Sons Funeral Home Inc.  
Burling 3-7501/1961 Broad Creek

Walter & Sons Funeral Home Inc.  
Burial: 5/26/1954 Broad Creek

2/26/1944 Blood Creek

Kingston, N. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |   | REG. NO. 8413481   |  |
|---|--|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LUCRETIA TWINE</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 4 84</b>                     |  | 2b. HOUR<br><b>10 AM</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 19 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.        |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHN L. DEATON MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>322 E. Lafayette Ave. 21202</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Armond Porter</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucretia Queen</b>  |  |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unkn</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Lucretia Colbert 322 E. Lafayette Avenue</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRO VASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>ORGANIC BRAIN LYNDROME</b>  |  |   |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>_____   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>_____         |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>_____   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>_____                                      |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>7/13</b> , 19 <b>82</b> , to <b>5/3</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>M. P. Daly M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>5/4/84</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. P. DALY</b>  |  |   |  | 22e. ADDRESS<br><b>40 DEATON MEDICAL CENTER</b>   |  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>5/8/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>           |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March Funeral Home</b>  |  |   |  |   |  | ADDRESS<br><b>1101 E. North Ave</b>                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 - 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

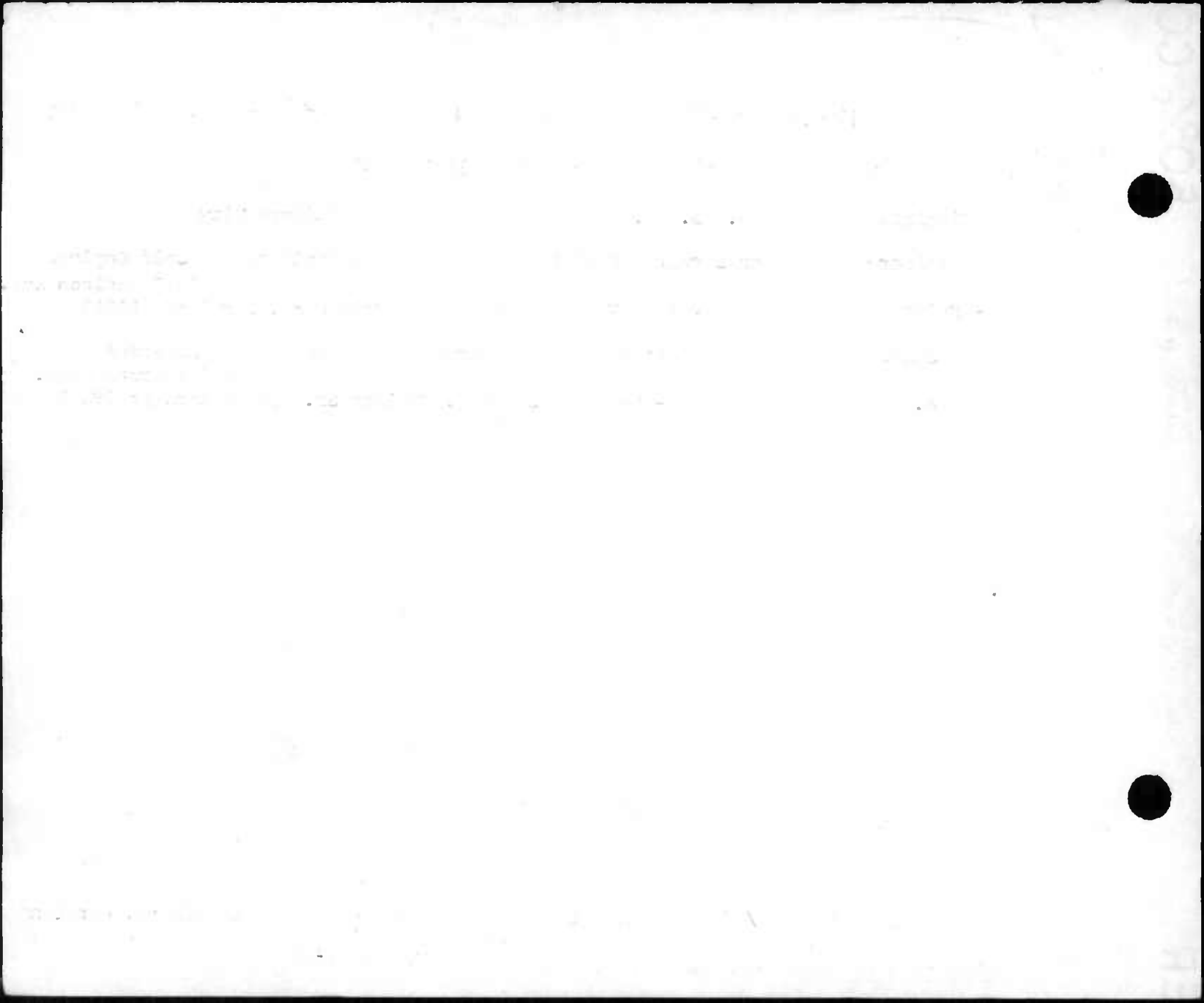
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 8413482 |  |
|---|--|---|--|---|--|--|--|---|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Pocahontas TYLER</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-3 -84</b>   |  | 2b. HOUR<br><b>7:19 AM</b>  |  |                  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 17 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>   |  |                  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1813 Madison Ave. Baltimore, Maryland 21217</b>                                    |  |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jacob Lipscomb</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Larah Lee Anderson</b>   |  |  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>241-09-4467B</b>   |  | 17. INFORMANT ADDRESS<br><b>James H. Gilliam Sr. Wilmington, De 19803</b>   |  |  |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br><b>2030</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Multiple myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b> |  |   |  |   |  |  |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Fracture of humerus, spinal pneumonia, decubitus ulcers</b>   |  |   |  |   |  |  |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/3/84</b> 19 <b>84</b> to <b>5/3</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |                  |  |
| 22b. SIGNATURE <b>James Evans MD</b> DEGREE <b>MD</b>   |  |   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>5/3/84</b>  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Evans MD</b>   |  |   |  | 22e. ADDRESS <b>700 Washington Blvd, Balto, Md 21230</b>  |  |  |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>5/8/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |   |  |                  |  |
| 24. FUNERAL DIRECTOR NAME <b>NUTTER + SONS FUNERAL HOME INC.</b> ADDRESS <b>2501 GWYNNS FALLS PKWY, BALTO, MD, 21216</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>   |  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEROY URGUHART</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-11-1984</b>   |  | 2b. HOUR<br>MIN.<br><b>11 AM</b>  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-22-1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>85</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY MD.</b>                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>935 W. LEXINGTON ST</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>21217</b>  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>BALTO</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>827 ARCADE AVE</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEE URGUHART</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LIZZIE WILLIAMS</b>   |  | 16. SOCIAL SECURITY NO.<br><b>218-078161</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><b>218-078161</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>ICEY FIELDS 935 W LEXINGTON ST</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Severe Anemia</b><br>(c) <b>B12 deficiency</b>  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>1 mon.</b><br><b>Indeterminate</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Dementia, Aortic Stenosis, Benign Prostatic Hypertrophy</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> , 19 <b>84</b> to <b>5-11</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE  |  | 22c. DATE SIGNED<br><b>5/15/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alvin R. Sills, MD</b>   |   | 22e. ADDRESS<br><b>4432 Park Heights Ave, Balto MD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE<br><b>5-16-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>  |   | 23e. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BROWN-THOMPSON</b>  |   | ADDRESS<br><b>1913 W BALTO ST</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed at this office having the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 4 8 4  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                                |  |
|--|--|---|--|---|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lilly M. UTZ |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 7 84                |   | 2b. HOUR<br>1:00A.M.           |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 30 10                     |                                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74<br>YRS.                     |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.        |                                |  |
| 12a. USUAL OCCUPATION<br>(TYPE OR NATURE OF WORKING LIFE)<br>Housewife   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking              |   |                                |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Baltimore |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob Ben tell                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mamie Clark |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 071838   |  | 17. INFORMANT<br>ADDRESS<br>Richard A. Utz 106 Manor Avenue 21206 |                                |  |

MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest<br>5198<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory Infection<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chronic Respiratory disease |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 mins.<br>5 days<br>Yrs. |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Congestive heart failure, Interstitial Fibrosis, diabetes

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2 19 84, to 5/7 19 84, that (I) (we) lost<br>saw the deceased give an above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 27b. SIGNATURE<br>C. E. Sheehan MD  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 27c. DATE SIGNED<br>5/7/84   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. E. Sheehan MD   |  | 27e. ADDRESS<br>University of Md. Hosp.                                |  |  |  |  |  |

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>5-10-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahu Funeral Home   |  | 25a. DATE REC'D. BY REGISTRAR<br>7401 BELAIR RD<br>BALTO. MD. 21204<br>MAY 10 1984 |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall     |  |   |  |





**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 1 3 4 8 5

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE  |  |
| FIRST MIDDLE LAST<br>Chester Uzialko  |  | Male   |  | White  |  |
| 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| MONTH DAY YEAR<br>10 21 30  |  | 53 YRS.  |  | Baltimore City MD.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9. CITIZEN OF WHAT COUNTRY?                                    |  | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Pa.   |  | U.S.A.   |  | St. Agnes Hospital   |  |
| 11. CITY OR TOWN OF DEATH   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Baltimore   |  | Supervisor   |  | Box Factory  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  |
| Md. A.A. Baltimore  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                       |  | 16. STREET ADDRESS / ZIP CODE  |  |
| FIRST MIDDLE LAST<br>Benjamin Uzialko   |  | FIRST MIDDLE LAST<br>Rose Pawfka                               |  | 606 Luther Street 21225  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 17b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT  |  |
| No  |  | 159-24-6118  |  | Glen Burnie, Md 21061  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  | 19. SOCIAL SECURITY NO.  |  | 20. ADDRESS  |  |
| IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>   |  | 159-24-6118  |  | Patricia Uzialko 121 Glendale Ave  |  |
| 3481  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  | (b) <u>HEPATIC ENCEPHALOPATHY, RENAL</u>                       |  | 26 DAYS  |  |
|   |  | (c) <u>FAILURE, SEPSIS, GI BLEEDING</u>                        |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |  | 20a. AUTOPSY?  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) |  | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost                               |  |  |  |  |  |
| saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated             |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| George Malhotra   |  |  |  | 5-26-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| R. MALHOTRA   |  | ST AGNES HOSP, BALT, MD 21229                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 5/30/84  |  | Glen Haven Mem Park  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                                  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| George J. Gonce 4001 Ritchie Hwy Balto Md   |  | MAY 29 1984  |  | Julia Davidson-Randall   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "P" item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                              |   |  |  |  |  |  |                             |   |
|---|------------------------------|---|--|--|--|--|--|-----------------------------|---|
| 1. FOR STATE REGISTRAR  |                              | 8 4 1 3 4 8 6<br>REG. NO.   |  |  |  |  |  |                             |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                              |   |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |                             | 2b. HOUR  |
| TICH VAN  |                              |   |  |  | 5/18/84  |  |  |                             | 145 AM  |
| 3. SEX  | 4. RACE                      | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR  |                             | IF UNDER 24 HRS   |
| Male  | Oriental                     | May 12, 1919  |  |  | 65 YRS.  |  | MONTHS DAYS  |                             | HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |                             |   |
| China   | Vietnam                      |   |  |  | BALTIMORE MD.  |  |  |                             |   |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                             |   |
| BALTIMORE CITY  |                              | UNION MEMORIAL HOSPITAL   |  |  | Unemployed   |  |  |                             |   |
| 13a. STATE  |                              |   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                             | 13d. INSIDE CITY LIMITS?  |
| Md.   |                              |   |  |  |  |  | Baltimore  |                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME   |                              |   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |                             |   |
| FIRST MIDDLE LAST   |                              |   |  |  | FIRST MIDDLE LAST  |  |  |                             |   |
| Van   |                              |   |  |  | Van  |  |  |                             |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                              |   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |                             |   |
| no  |                              |   |  |  | 574-36-0381  |  | Tuan Van Same  |                             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1519 IMMEDIATE CAUSE (a) <u>Gastric Carcinoma</u> SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>gastric carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                              |   |  |  |  |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |                              |   |  |  |  |  |  |                             |   |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                             |   |
|   |                              |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                             |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                             |   |
|   |                              |   |  |  |  |  |  |                             |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |                             |   |
|   |                              |   |  |  |  |  |  |                             |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17, 19 84, to 5/18, 19 84, that (I) (we) last saw the deceased alive on 5/18, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.  |                              |   |  |  |  |  |  |                             |   |
| 22b. SIGNATURE<br>Paul Miller   |                              |   |  |  | DEGREE<br>MD   |  |  | 22c. DATE SIGNED<br>5/18/84 |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL MILLER MD   |                              |   |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL                          |  |  |                             |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                             |   |
| Burial  |                              | May 21, 1984  |  | Parkwood   |  | Baltimore Md.                              |  |                             |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |                              |   |  |  | 25a. DATE REC'D. BY REGISTRAR                                    |  | 25b. REGISTRAR'S SIGNATURE                                     |                             |   |
| Leonard J. Ruck Inc. Baltimore, Maryland  |                              |   |  |  | MAY 22 1984  |  | John Davidson-Randall  |                             |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 84 REG. NO. 13487  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clara VanBlargan   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 3 84  |   |  | 2b. HOUR<br>7:10PM                                    |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 11 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md... 13b. COUNTY Howard 13c. CITY OR TOWN Elkridge  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>5785 Paradise Ave. 21227   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Hassenpflug  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ninnie Stewart  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT ADDRESS<br>Carole Rawlings Same as #13e   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Cardiac Arrest  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Myocarditis   |  |  |  |   |  |   |  | 15 yrs  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertension  |  |  |  |   |  |   |  | 20 yrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24 1967 to 5/3 1984, that (I) (we) last saw the deceased alive on 1/25 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Robert S. McCeney, M.D.   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>5/4/84   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert S. McCeney, M.D.  |  |  |  |   | 22e. ADDRESS<br>402 Main St., Laurel, Md. 20707  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/7/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lilly Dale Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lilly, Penn.                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>FLECK FUNERAL HOME INC.<br>7601 Sandy Spring Rd. Laurel Md. 20707   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES VANHORN</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 12, 1984</b>   |  | 2b. HOUR<br><b>10:30 A M</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11-24-1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bel Air Convalesarium Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6116 BelAir Rd. 21206</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>432-04-2372</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Ross 6116 BelAir Rd.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>2030 Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>months</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF <b>1 (+) years.</b><br>(c) |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arteriosclerotic Cardiovascular Disease</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/84</b> to <b>5/12/84</b> , that (I) (we) lost <b>10/11/84</b> to <b>5/12/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERT B. BRADLEY</b>   |  |   |  | 22c. DATE SIGNED<br><b>May 12, 1984</b>   |  |   |  | 22d. ADDRESS<br><b>4900 BELAIR ROAD BALTIMORE, MARYLAND #06</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-15-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. A.A. Md.</b>                               |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Chas A. Rice FSPA 1300 Eutaw Pl</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 18 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 REG. NO. 13489

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                                      |  |
|---|--|--|---|---|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Bessie Pearl Varnier</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 16 84</b> |   | 2b. HOUR<br><b>8<sup>45</sup> AM</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 98</b>  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Va</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hosp</b>        |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |                                      |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MO</b>   |  | 13b. COUNTY<br><b>=====</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Reason Stewart</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Ella McElroy</b>  |   | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                               |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>239-09-4124</b>   |   | 17. INFORMANT ADDRESS<br><b>Evelyn Kowalewski Same as 13e</b>   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4151 Pulmonary thrombosis Complicating adenocarcinoma of uterus</b><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |                                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>May 13, 1984</b> , to <b>May 16, 1984</b> , that (I (we) last saw the deceased alive on <b>May 16, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death.   |  |  |   |   |                                      |  |
| 22b. SIGNATURE<br><b>Greenfield</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5-16-84</b>  |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert J. Neufeld</b>   |  | 22e. ADDRESS<br><b>South Baltimore Gen. Hosp</b>   |   |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/18/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |                                      |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Balto</b>   |  | COUNTY<br><b>A.A.</b>  |   | STATE<br><b>Md</b>  |                                      |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1984</b>   |                                      |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3490

|   |  |                                     |           |  |  |   |  |   |  |   |  |
|---|--|-------------------------------------|-----------|--|--|---|--|---|--|---|--|
| FOR REGISTRAR   |  |                                     |           |  |  |   |  |   |  |   |  |
| 1- REGISTRAR  |  |                                     |           |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                                     |           |  |  |   |  |   |  |   |  |
| FIRST MILDRED   |  |                                     | MIDDLE O. |  |  | LAST VASSAR   |  |   |  |   |  |
| 3. SEX<br>F   |  | 4. RACE<br>B                        |           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 10 30  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>54 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                       |  | 7c. DATE OF DEATH<br>MONTH DAY YEAR<br>5-22-84 19                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |           |  |  | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City        |  | 7d. HOUR<br>3:47P<br>M  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                                     |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>640 Pitcher Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY                         |           | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br>640 Pitcher Street                     |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wheeler Chilabress  |  |                                     |           |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Ferguson   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                                     |           | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT ADDRESS<br>Los Angeles, CA<br>Barbara Vassar 1653 Sierra Bonita   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular</u><br>DISEASE OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <u>disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                     |           |  |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                                     |           |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                                     |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                                     |           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .    |  |                                     |           |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u>   |  |                                     |           |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   | MEDICAL EXAMINER   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                                     |           |  |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                                     |           | 23b. DATE<br>5/29/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.C. March F/H, Inc., 1101 E. North Ave.  |  |                                     |           |  |  | 25a. DATE REC'D. BY REGISTRAR<br>29 1984  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randell</u> |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413491

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES B. VAUGHN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 23, 1984</b>                                      |  | 2b. HOUR<br>A<br><b>2:43</b><br>M  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 20 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>bas electric Co</b>  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1300 E. Lantana St 21213</b>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Angela Vaughn 1300 E. Lantana St</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1850</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>urinary tract sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic prostate cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0</b><br><b>1-2 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/23 1984</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>5/22</b> , 19 <b>84</b> , to <b>5/23</b> , 19 <b>84</b> , that (ii) (we) last saw the deceased alive on <b>5/23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Peter C. Belitsos</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>5/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter C. Belitsos MD</b>   |  | 22e. ADDRESS<br><b>600 N. Broadway St. 21205 Baltimore</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>5/25/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Md.</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Locke Funeral Home</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |

MEDICAL CERTIFICATION

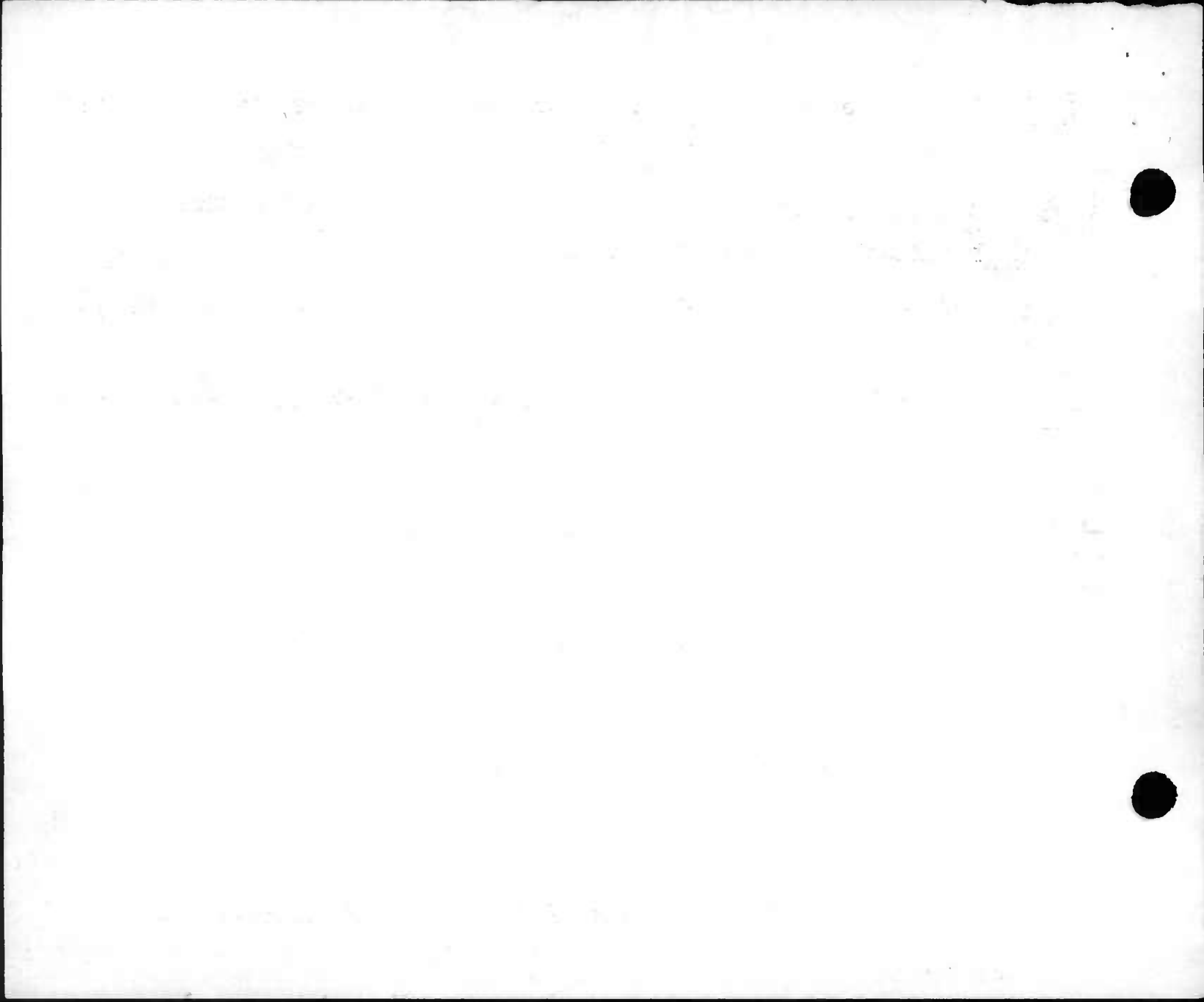
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |                  |   |  |   |  | REG. NO. 3492                                |  |
|---|-------------------------|---|--|---|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEON VAUGHN</b>  |                         |   |  |   |                  | 2a. DATE KNOWN OF DEATH<br>MATED <input checked="" type="checkbox"/> 5 24 1984  |  | 2b. HOUR<br>M 4:21 P M  |  |  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 2 06 77</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>77</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5 24 1984</b>                  |  | 7d. HOUR<br>P M   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hosp. (DOA)</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |                         |   |  |   |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |                         |   |  |   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HATTIE ?</b>                |  | 16. SOCIAL SECURITY NO.<br><b>213-07-5338</b>                                       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |   |  |   |                  | 17. INFORMANT<br>ADDRESS<br><b>MRS CARA L. VAUGHN 908 EDMONDSON AVE.</b>        |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).             |                         |   |  |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19  |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |                  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |                         |   |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER  |                  |   |  | DATE SIGNED<br><b>5-25-84</b>   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>   |                         |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)   |                         | 23b. DATE<br><b>5-30-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM PK</b>   |                  | 23d. LOCATION<br>OR TOWN COUNTY STATE<br><b>ARBUTUS BALTO. CH. MD</b>           |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOSEPH L. RUSS 2222 W. NORTH AVE.</b>  |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>  |                  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Russell</i>                      |  |   |  |  |  |

MEDICAL CERTIFICATION

(A)





#5,6,per call w/F.H.

STATE OF MARYLAND

1. FOR  
STATE  
REGISTRAR

5/16/84 kam

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 4 9 3  
REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA</b> <b>VAVRINA</b>  |  | 2a. DATE OF DEATH<br><b>MAY 8, 1984</b>   |   | 2b. HOUR<br><b>10:03p</b>   |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>1882</b><br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> <b>101</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME AND HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4001 Ridgcroft Rd. 21206</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>GEORGE</b> MIDDLE LAST <b>RICKER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE LAST <b>OVERSIDER</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-48-1099</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Arthur Hauser 3425 Shannon Dr. 21213</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>March 28</u> 19 <u>84</u> , to <u>May 8</u> 19 <u>84</u> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <u>May 8</u> 19 <u>84</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> we did not view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>R. Sood</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>5/8/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. SOOD MD.</b>   |  | 22e. ADDRESS<br><b>100 N. Broadway Baltimore, Md</b><br><b>CHURCH HOME HOSPITAL 21231</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>5-11-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LISSANN FUNERAL HOME</b>   |  | ADDRESS<br><b>1401 BELAIR RD BALTO. MD 21206</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1984</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |  |  |               |
|--|--|---|---|---|--|--|--|--|--|---------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Emily Veale</b>   |  |   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-13-84</b>                                |  |  |  |  | 2b. HOUR<br>M |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-16-18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS<br><b>65</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>65</b>                        |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>65</b> |  |               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                   |  |  |  |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4416 Finney Ave. (Home)</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |               |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1604 Cliftview Ave. (13)</b>                    |  |  |  |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mac Laisster</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Mae Lassiter</b>  |   |  |  |  |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>239-48-4604</b>  |   | 17. INFORMANT ADDRESS<br><b>Archie Veale 1604 Cliftview Ave (13)</b>                            |  |  |  |  |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adenocarcinoma of Unknown Primary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>1991</b> |  |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>2 months</b><br><b>12 months</b> |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>11a</b>  |  |   |   |   |  |  |  |  |  |               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>August 12, 1980</b> , to <b>May 13, 1984</b> , that (b) (we) lost saw the deceased alive on <b>May 9, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |               |
| 22b. SIGNATURE<br><b>Lawrence E Klein M.D.</b>   |  |   |   | DEGREE<br><b>M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>5/15/84</b>         |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Elliot Klein M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>Harvey 502, Johns Hopkins Hospital.</b>                                      |  |  |  |  |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-19-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Veale Cemetery</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lewiston N.C.</b> |  |  |  |               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas.A.Rice FSPA</b>  |  |   |   | ADDRESS<br><b>1300 Eutaw Place</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 18 1984</b>                |  |  |  |               |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 4 9 5  
REG. NO.FOR  
1 - STATE  
REGISTRAR

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LENA - VINCI  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 12 84  |   | 2b. HOUR<br>3:53 AM  |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB. 9 1898   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ITALY  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>COACH CLEANER               | 12b. KIND OF BUSINESS OR INDUSTRY<br>B & O R.R.                           |  |
| 13a. STATE<br>MD.   | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>352 GUSRYAN ST. 21224                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SALVATORE - CASSINISI   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY - FAZIO   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>212-01-6390   | 17. INFORMANT<br>ADDRESS<br>MARY KADLEC (DGHTER) SAME ADDRESS                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u><br><u>4280</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>84</u> , to <u>5-12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5-12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Ronald Sakamoto</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>5-12-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Ronald Sakamoto</u>   |   | 22e. ADDRESS<br><u>Mercy Hosp, 3015 N. Ave, Balt. Md 21202</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   | 23b. DATE<br>5/14/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER   | 23d. LOCATION<br>BALTIMORE COUNTY Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHIMUNEK FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto. Md. 21213  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 17 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3331 B-1  
RECEIVED  
JAN 10 1954

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |  |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PATRICK L. VINES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 13, 1984</b>                   |   | 2b. HOUR<br><b>4:30P</b> M                                      |  |   |  |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 17, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 74 MRS.<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1912 W. SARATOGA STREET</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SUGAR REFINERY</b>   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1912 W. SARATOGA ST. 21223</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS VINES</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AMMY ATKINSON</b>        |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                               |   |  |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212 09 6189</b>  |  |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. RACHEL VINES 1912 W. SARATOGA STREET</b> |   |   |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of prostate with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>425 84 513 84</b>  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> 19 <b>84</b> , saw the deceased alive on <b>5/11</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Kuang-yen Huang</b>  |  |   | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>5/15/84</b>                                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  |   | 22e. ADDRESS<br><b>BON Secours Hospital</b>                                  |   |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>5/18/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. NAT. MEM. PARK</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL (PRINCE GEO.) MD.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>   |  |   |  |   |   | ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Randell</b> |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAY 13, 1964

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MAY 17, 1965

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1912 W. BARNARD STREET

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1912 W. BARNARD STREET

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NO

1912 W. BARNARD STREET

ALBANY

(ALBANY CELL) NO.

ALBANY

ALBANY

5/16/64

ALBANY

ALBANY T. GUYNE 4517 PARK HIGHLAND AVENUE



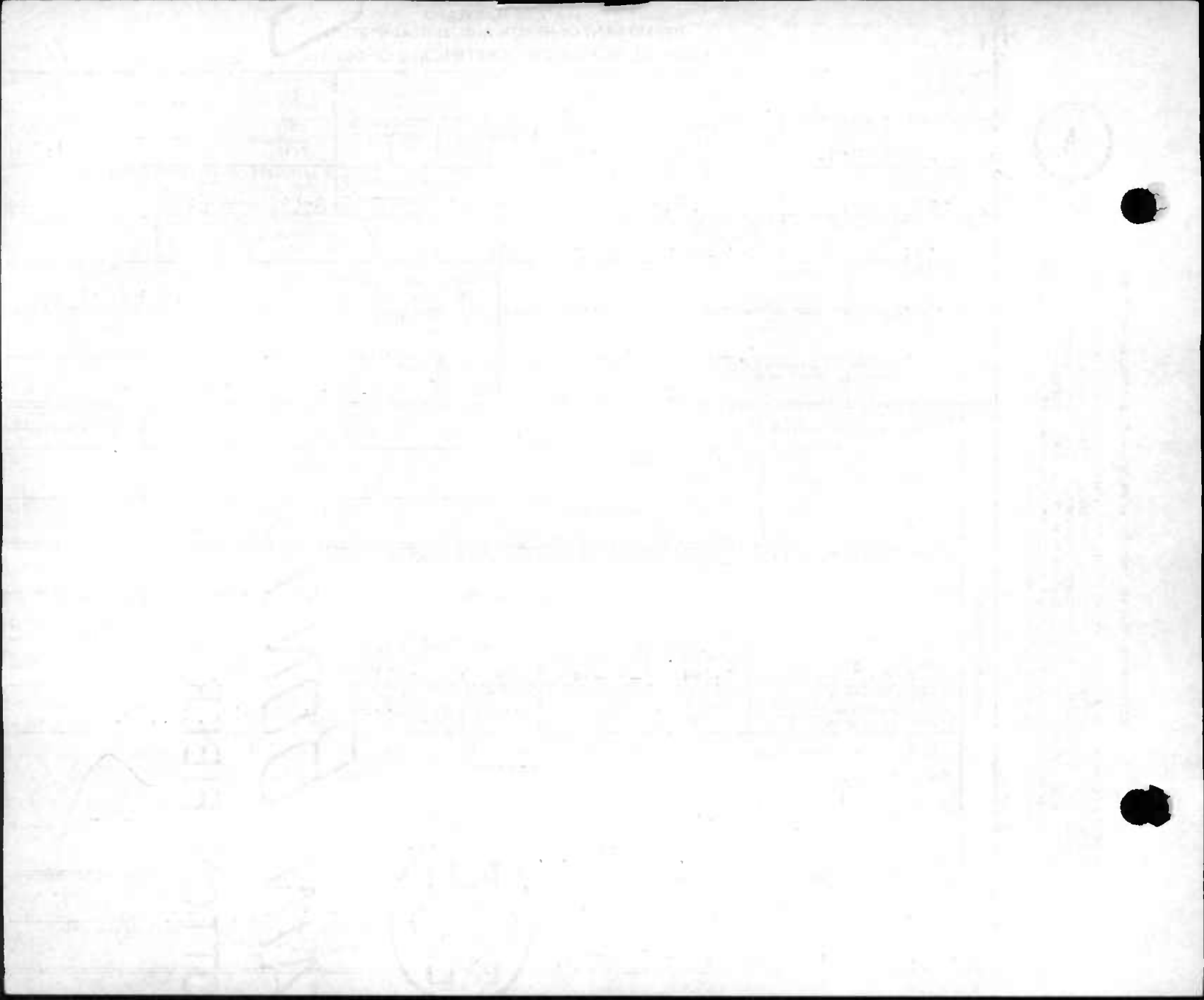
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3497

|   |  |         |                   |  |  |                                    |  |   |                |  |  |   |  |          |  |
|---|--|---------|-------------------|--|--|------------------------------------|--|---|----------------|--|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST |  |  | 7a. DATE KNOWN OF DEATH            |  |   | MONTH DAY YEAR |  |  | 7b. HOUR  |  |          |  |
| JEANNE R. VOCCI   |  |         |                   |  |  | 5-26-84                            |  |   | 19             |  |  | M   |  |          |  |
| 3. SEX  |  | 4. RACE |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.  |                | IF UNDER 24 HRS.                           |  | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR |  |
| Female  |  | Cauc.   |                   | 11-15-62   |  | 21 YRS.                            |  | MONTHS DAYS   |                | HOURS MIN                                  |  | 5-26-84   |  | 19 4:56P |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |  |
| Maryland  |  |         |                   | U.S.A.   |  |                                    |  |   |                |  |  | Baltimore City MD.  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| Baltimore   |  |         |                   | University Hospital STU  |  |                                    |  | mixologist  |                |  |  | Schaefer's  |  |          |  |
| 13a. STATE  |  |         |                   | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |                | 13e. STREET ADDRESS                        |  |   |  |          |  |
| Md.   |  |         |                   |  |  | Balto.                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                | 6009 Winthrop Rd/21206                     |  |   |  |          |  |
| 14. FATHER'S NAME   |  |         |                   | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |   |                |  |  |   |  |          |  |
| FIRST MIDDLE LAST   |  |         |                   | FIRST MIDDLE LAST  |  |                                    |  |   |                |  |  |   |  |          |  |
| Frank J. Vocci  |  |         |                   | Jeanne R. Gordon   |  |                                    |  |   |                |  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |         |                   | 16b. SOCIAL SECURITY NO.   |  |                                    |  | 17. INFORMANT ADDRESS   |                |  |  |   |  |          |  |
| no  |  |         |                   | 219-58-4152  |  |                                    |  | Mr. & Mrs. Frank Vocci, same  |                |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8292 IMMEDIATE CAUSE (a) Heart Laceration<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |         |                   |  |  |                                    |  |   |                |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |                   |  |  |                                    |  |   |                |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                    |  |   |                |  |  | 20. AUTOPSY?  |  |          |  |
|   |  |         |                   |  |  |                                    |  |   |                |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |                   | 21b. TIME OF INJURY<br>3:08PM 5-26-84  |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject fell from a horse  |                |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street                                      |  |                                    |  | 21f. LOCATION<br>4300 Northcliff Road Balto.Co., Md.  |                |  |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |         |                   |  |  |                                    |  |   |                |  |  |   |  |          |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.   |  |         |                   | TITLE (SPECIFY)<br>Assistant   |  |                                    |  | DATE SIGNED<br>5-27-84  |                |  |  |   |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |         |                   | ADDRESS  |  |                                    |  |   |                |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |                   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   |                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |  |          |  |
| Burial  |  |         |                   | 5/30/84  |  | Gardens of Faith                   |  |   |                | Baltimore, Maryland                        |  |   |  |          |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |                   | ADDRESS  |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR   |                |  |  | 25b. REGISTRAR'S SIGNATURE  |  |          |  |
| Joseph N. Zannino Funeral Home, 21224   |  |         |                   |  |  |                                    |  | MAY 29 1984   |                |  |  |   |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR VIOLES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, (AT 201 PRIOR TO BURIAL, CREMATION, OR REMOVAL).



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

 8413498  
 REG. NO.

|  |  |  |                                      |   |  |
|--|--|--|--------------------------------------|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |                                      | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |                                      | 2b. HOUR  |  |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR   |                                      | HOURS MIN.  |  |
| CHARLES A. VOLZ  |  | 5 19 84  |                                      | 6:50 P.M.   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE                               | 7. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Male   | White  | 9-27-1902  | 81                                   | Baltimore City  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| Harford Co. Md.  | U.S.A.   |  | Baltimore City                       |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY    |   |  |
| Baltimore  | North Charles General Hosp.  | Retired  | Fullerton Supply                     |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                  |   |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 7548 Belair Rd.-21236                |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |                                      |   |  |
| Charles A. Volz  |  | Catherine Morelock   |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT ADDRESS   |  |
| No   |  | 216-10-7146  |                                      | Mrs. Margaret K. Lotz - 7548 Belair Rd.-21236                       |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  |  |  |                                      |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |                                      |   |  |
| IMMEDIATE CAUSE (a) Cardiopulmonary arrest   |  |  |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease   |  |  |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |                                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                                      |   |  |
| Congestive heart failure, atrial fibrillation  |  |  |                                      |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20a. AUTOPSY?   |  |
|  |  |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |                                      | 21c. HOW INJURY OCCURRED  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |                                      | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |                                      | 21f. LOCATION   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/19 19 84 to 5/19 19 84, that (I) (we) last saw the deceased alive on 5/19 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                      |   |  |
| 22b. SIGNATURE   |  | DEGREE   |                                      | 22c. DATE SIGNED  |  |
| Veneranda G. Barnes  |  |  |                                      | 5/19/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |                                      |   |  |
| VENERANDA G. BARNES  |  | NORTH CHARLES GEN. HOSP.   |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                                      | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |
| Burial   |  | 5-23-84  |                                      | St. Paul's Luth. Cem.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |                                      | 25b. REGISTRAR'S SIGNATURE  |  |
| John C. Miller Inc-6415 Belair Rd.-21206   |  | MAY 22 1984  |                                      | Davidson-Rindell  |  |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

John C. Miller Inc-6415 Delair St.-21205

Buried 7-23-84 St. Paul's Luth. Ch. Fenwick, Md.

no

210-10-7146

Mr. Margaret K. La+ - 7418 Delair St.-21232

Charles A. Volf

Mr. Baltco. Baltco.

Catherine Horvack

7418 Delair St.-21232 x

Baltimore

North Charles General Hosp.

Retired

Fulton Supp.

Harford Co. Md. U.S.A.

Baltimore City

Male White

9-27-1902

81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in.20  
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 4 9 9  
REG. NO.

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY M VONDERHEIDE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-13-84</b>  |   | 2b. HOUR<br><b>10<sup>00</sup> A.M.</b>  |  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 13, 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>400 Northway 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Manns</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Lautenschlager</b>  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 38 2560</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Emma V. Rhoderick, Same</b>                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac/Respiratory Arrest</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Cardiomyopathy; chronic atr. fibrillation</b> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0</b>   |   |  |
|  |  |   |  |   |  |  |   | <b>2 hrs</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Cor. Art. Dz, pericardial effusion, mitral regurg.</b>  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>5/13/84</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cor. Art. Dz</b>  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1984</b> to <b>May 13, 1984</b> , that (I) (we) last saw the deceased alive on <b>5/13</b> , 19 <b>84</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Margaret Vaughan</b>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>5/13/84</b>   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Margaret Vaughan</b>   |  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5/17/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, MD</b>                             |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., MD 21212</b>  |  |   |  |   | 25a. DATE RECD. BY REGISTRAR<br><b>MAY 15 1984</b>                             |  |   |  |   |  |



April 10, 1962

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11-10-62

April 10, 1962

April 10

Henry W. Johnson, Jr.

New York City, N.Y. 10011

Highly sensitive

MC

BP

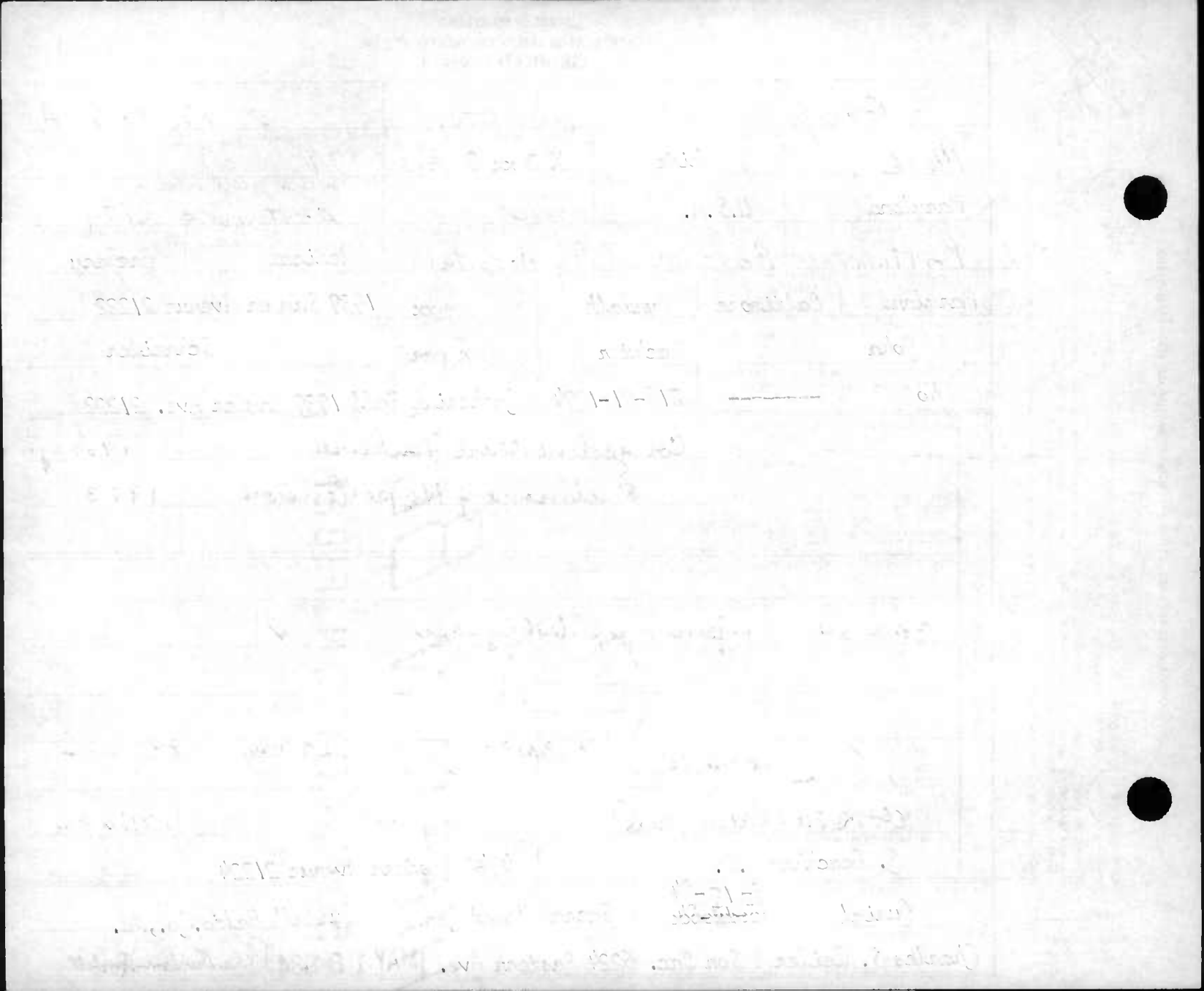
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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |  |                                      |                                   |  | 8413500                                      |  |
|---|--|--|---|--|---|--|--------------------------------------|-----------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  | REG. NO.  |  |   |  |                                      |                                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |   | 2a. DATE OF DEATH  |                                      |                                   | MONTH DAY YEAR 2b. HOUR  |  |  |
| George W. Wachter   |  |  |   |  |   | 5 17 84  |                                      |                                   | 6 AM   |  |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                   |  | IF UNDER 1 YEAR                              |  |
| Male  |  | White  |   | A 2 x 28 1913  |   |  | 71                                   |                                   |  | YRS. MONTHS DAYS                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                   |  |  |  |
| Maryland  |  | U.S.A.   |   |  |   |  | Baltimore City                       |                                   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) |  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Baltimore   |  | Baltimore City Hospitals   |   |  | Retired   |  |                                      | Brewery                           |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      | 13e. STREET ADDRESS               |  |  |  |
| Maryland  |  | Baltimore  |   | Dundalk  |   |  |                                      | 1939 Snyder Avenue 21222          |  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN)   |                                      |                                   | 16b. SOCIAL SECURITY NO.                                       |  |  |
| John Wachter  |  |  | Margaret Schneider  |  |   | No   |                                      |                                   | 216-01-1994  |  |  |
|   |  |  |   |  |   | 17. INFORMANT  |                                      |                                   | ADDRESS  |  |  |
|   |  |  |   |  |   | Catherine Hall   |                                      |                                   | 1939 Snyder Ave. 21222   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |   |  |                                      |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |   |  |                                      |                                   |  |  |  |
| IMMEDIATE CAUSE (a) Congestive Heart Failure  |  |  |   |  |   |  |                                      |                                   |  | 1983 yr.                                     |  |
| 4160  |  |  |   |  |   |  |                                      |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |   |  |                                      |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |   |  |                                      |                                   |  |  |  |
| (b) Pulmonary Hypertension  |  |  |   |  |   |  |                                      |                                   |  | 1973   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |   |  |                                      |                                   |  |  |  |
| (c)   |  |  |   |  |   |  |                                      |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |   |  |                                      |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY?  |                                      |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 3 May 84  |  |  | Femoro-popliteal bypass   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                      |                                   |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |  |   |  |                                      |                                   |  |  |  |
|   |  |  | P.M. 19   |  |   |  |                                      |                                   |  |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION  |                                      |                                   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   |  |   | STREET CITY OR TOWN COUNTY STATE   |                                      |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 Apr 84, 19, to 17 May 84, that (I) (we) lost saw the deceased alive on 16 May 84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |                                      |                                   |  |  |  |
| 22b. SIGNATURE  |  |  |   |  |   | DEGREE   |                                      |                                   | 22c. DATE SIGNED   |  |  |
| E. Beachham M.D.  |  |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      |                                   | 17 May 84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  |   | 22e. ADDRESS   |                                      |                                   |  |  |  |
| E. Beachham M.D.  |  |  |   |  |   | 4940 Eastern Avenue 21224  |                                      |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                      |                                   | 23d. LOCATION  |  |  |
| Burial  |  |  | 5-19-84   |  |   | Sacred Heart Cem.  |                                      |                                   | Dundalk Balto. Co. Md.   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                      |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |  |
| Charles S. Zeiler & Son Inc. 6224 Eastern Ave.  |  |  |   |  |   | MAY 18 1984  |                                      |                                   | Lelia Davidson-Randall   |  |  |





## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 13501

REG. NO.

1 - FOR  
STATE  
REGISTRAR

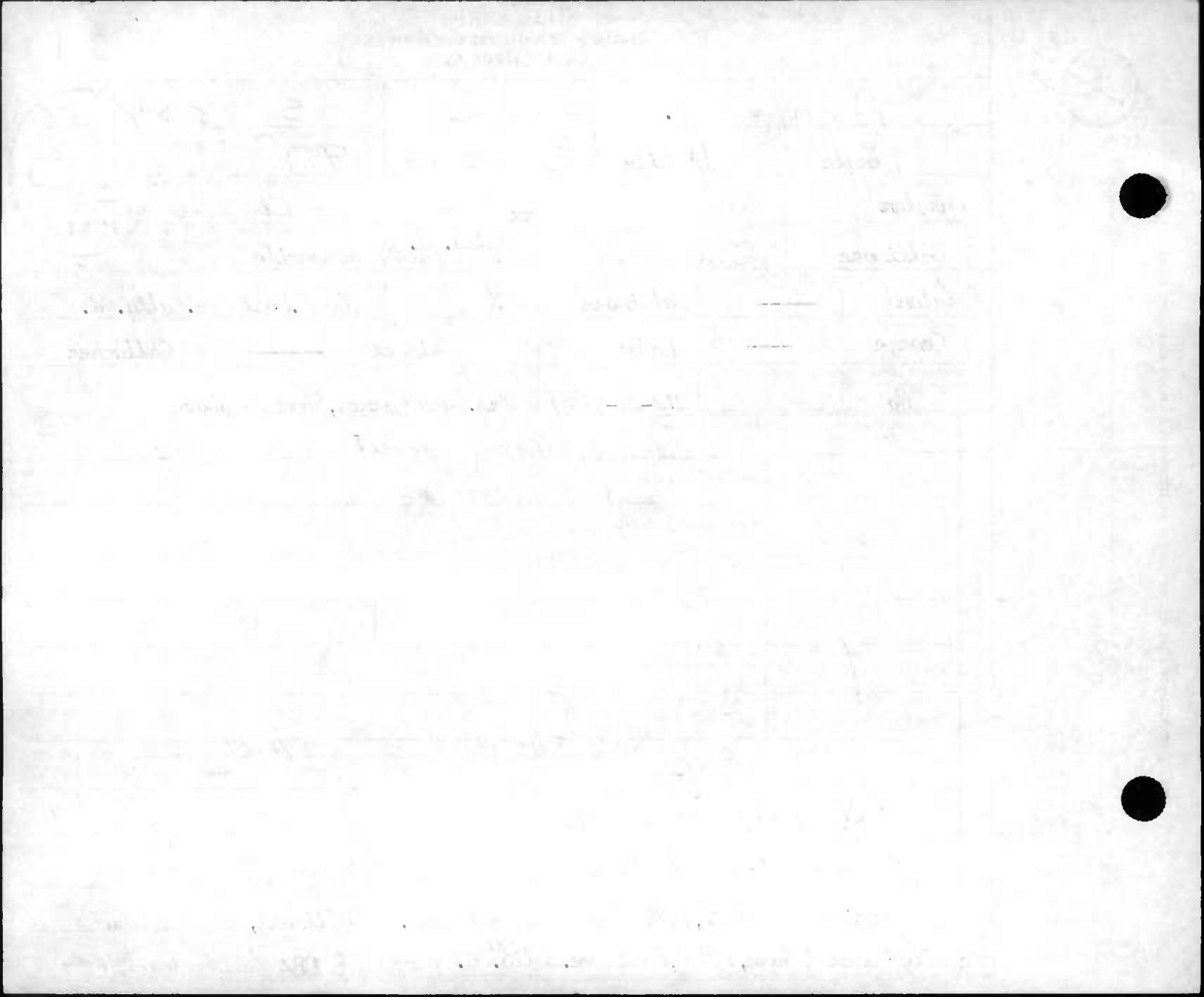
|  |  |  |   |   |                         |  |  |
|--|--|--|---|---|-------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Annie E. Wade</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 18 84</i> |   | 2b. HOUR<br><i>6 AM</i> |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 22 86</i>  |                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>97</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Luthenan Hospital</i>  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br>-----   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George LaMar</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bridget Gallagher</i>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |                         | 16b. SOCIAL SECURITY NO.<br><i>212-24-9586T</i>  |  |
| 17. INFORMANT<br>ADDRESS<br><i>Mrs. Mary Ganner, Same as above</i>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>gastric carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ----- |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>NO</i>   |  |  |   |   |                         |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                         |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                         |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/18/84</i> 19____, to <i>5/18/84</i> 19____, that (I) (we) last saw the deceased alive on <i>never</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |   |                         |  |  |
| 22b. SIGNATURE<br><i>Robert W. Henry MD</i>  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                         | 22c. DATE SIGNED<br><i>5/18/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert W. Henry MD</i>   |  | 22e. ADDRESS<br><i>Luthenan Hospital</i>   |   | 22f. DATE REC'D. BY REGISTRAR   |                         | 22g. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>May 21, 1984</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral Cemt.</i>  |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</i>   |  | 24b. ADDRESS<br><i>21230</i>   |   | 24c. DATE REC'D. BY REGISTRAR   |                         | 24d. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- STATE REGISTRAR   |  | Charles W. WAGONER  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 84 13502  |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHARLES W. WAGONER</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 21 84</b>  |  | 2b. HOUR<br><b>124p</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 2 11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>73</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSP</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sanitation Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. Cup Co.</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY<br><b>MARYLAND --</b>   |  |   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry C. Wagoner</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nannie (unknown)</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW-II 217 104305</b>   |  | 17. INFORMANT ADDRESS<br><b>L. Marie Wagoner/1844 W Pratt St/Balto Md 21223</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 Acute myocardial infarction</b><br>IMMEDIATE CAUSE (a) }<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>8 months</b> |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic obstructive pulmonary disease</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 20</b> , 19 <b>84</b> , to <b>May 20</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>May 20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. Sgmin</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5-20-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUYOTA SAPSIRI, MD</b>   |  |   |  | 22e. ADDRESS<br><b>Bon Secours Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>05/23/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematorium</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville, Maryland 21228</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Walters Funeral Home/Pratt &amp; Stricker Streets Balto Md 21223</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |

BP

1

TO THE HONORABLE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

Very respectfully,  
Your obedient servant,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413503

REG. NO.

|   |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| THOMAS CHARLES WALDHAUSER   |  |  |  | 5 26 84  |  |  |  | 6:35P M   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  |
| Male  |  | White  |  | 4 21 13  |  | 71 YRS.  |  | MONTHS  |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | BALTIMORE, CITY  |  |   |  | MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore   |  | VAMC, BALTIMORE, MD. 21218   |  |  |  | Retired  |  | Nestles Co.   |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Maryland  |  |  |  | Baltimore  |  | Harbor View  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 520 South 47th. Street 21224                                   |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| John A. Waldhauser  |  |  |  | Margaret Kreppele  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| Yes   |  |  |  | W.N. 11  |  | Gertrude Walhauser 520 S. 47th. Street   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 4280 IMMEDIATE CAUSE (a) CARDIOPULM - ARREST  |  |  |  |  |  |  |  |   |  | 5/26 12  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS   |  |  |  |  |  |  |  |   |  | 5/26 1Pn   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CHF / DEBILITATION   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY STATE   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  | STREET   |  |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 5/25/84 to 5/26/84, that (X) (we) lost the deceased alive on 5/25/84, and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| Harry A. Allen MD   |  |  |  |  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |
| HARRY A. ALLEN MD   |  |  |  |  |  | 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218                                     |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |
| Burial  |  |  |  | 5-30-84  |  | Sacred Heart Cem.  |  | Dundalk, Balto. Co., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Charles S. Zeiler & Son Inc. 6224 Eastern Ave.  |  |  |  |  |  | MAY 29 1984  |  | John Davidson-Randall   |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413504  
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT Earl WALES</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 25 1984</b>   |  | 2b. HOUR<br><b>9:00 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 26, 1944</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Architect</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Glenn E. Wales</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Doris Matthews</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>090-36-7430</b>  |  | 17. INFORMANT <b>Widow:</b> ADDRESS<br><b>Kathleen D. Wales, 335 Warren Ave. 21230</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic colon cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Malnutrition 2° to bowel obstruction</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. . . . . 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>5/25</b> 19 <b>84</b> , to <b>5/25</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/25</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James D. Spearman</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>5/25/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES D. SPEARMAN</b>   |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/29/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Val. Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>STEWART &amp; MOWEN CO., 108 W. NORTH AVE. 21201</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

RECEIVED



New York

U.S.A.

XX

Nov. 20, 1944

Nov. 20, 1944

WASHINGTON CITY

WASHINGTON CITY, DISTRICT OF COLUMBIA

1000 Western Avenue, N.W.

Washington, D.C.

1000-10000 Washington Ave., N.W.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

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Washington, D.C.

Washington, D.C.

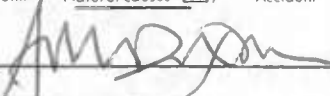

Washington, D.C.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/B2

| FOR STATE REGISTRAR  |  |                         |  |  |   |  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |   |  |  |  |  |  | REG. NO. 1. 3 5 0 5 |  |
|--|--|-------------------------|--|--|---|--|--|---|--|---|--|--|--|---|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CLAUDE WALKER</b>   |  |                         |  |  |   |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5 8 19 84</b>          |  |  |  | 2b. HOUR<br><b>10:27</b>  |  |  |  |  |  |                     |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 29 1920</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>64 YRS.</b> |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>5 8 19 84</b>                      |  |   |  | 7d. HOUR<br><b>10:27</b>                       |  |  |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                |  |   |  |  |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2419 W. North Ave.</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b> Co.                     |  |   |  |  |  |  |  |                     |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  |  |   |  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  |  |  | 13e. STREET ADDRESS<br><b>2419 W. North Avenue</b><br><b>Baltimore, Maryland 21216</b> |  |                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Tyson Walker</b>   |  |                         |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sellie Drayton</b> |  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No.</b>                        |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-12-0002</b> |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mabel Green Baltimore, Maryland 21216</b>             |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____  |  |                         |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.   |  |  |  |   |  |  |  |  |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                         |  |  |   |  |  |   |  |   |  |  |  |   |  |  |  |  |  |                     |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |   |  |  |  |  |  |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |  |  |  |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |   |  |  |   |  |   |  |  |  |   |  |  |  |  |  |                     |  |
| ACTUAL SIGNATURE    |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |   |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>5-8-84</b>  |  |   |  |  |  |  |  |                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |   |  |  |   |  |   |  |  |  |   |  |  |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>5/11/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>         |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                   |  |  |  |   |  |  |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Nutter &amp; Sons Funeral Home Inc.</b>  |  |                         |  |  |   | ADDRESS<br><b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>           |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |  |  |                     |  |



Name

Address

City

State

No.

Phone

U. S. A.

Business

Home

12-12-1964

Report

Construction

2125 N. North Ave.  
Baltimore, Maryland 21216

Division

2125 N. North Ave.

Baltimore, Maryland 21216

W. B. R. & Co. Inc.

MAY 9 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 13506  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET SUE WALKER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 25 1984</b>  |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT 26 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>62</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1833 E. LOMBARD ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PACKER</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRINTING</b>  |  | 13a. STATE<br><b>MD</b>   |  |   |  |  |  |
| 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1833 E. LOMBARD ST 21231</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN L WATERS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>DAISY</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>236-26-4010</b>  |  | 17. INFORMANT ADDRESS<br><b>PHILIP WALKER 1833 E. LOMBARD ST</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Ca lung &amp; metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>old MI w/ coro</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____ |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. A. Krowl</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. A. Krowl</b>   |  |   |  | 22e. ADDRESS<br><b>223 B. Blvd BALTO MD 21221</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/29/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILLS CEM</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHASE MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOHN M WEBER &amp; SONS INC CHESTER ST MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

1

1. The purpose of this document is to provide information regarding the status of the program and the results of the study conducted during the period from 1 January 1981 to 31 December 1981.

2. The study was conducted in accordance with the plan of work approved by the Joint Chiefs of Staff on 15 October 1980.

3. The results of the study are summarized in the following table:

| Category   | Number of Cases | Percentage of Total |
|------------|-----------------|---------------------|
| Category A | 12              | 12.5%               |
| Category B | 18              | 18.8%               |
| Category C | 25              | 25.8%               |
| Category D | 30              | 31.3%               |
| Category E | 15              | 15.6%               |

4. The data indicates that the majority of cases (66.7%) are in Categories C and D, which represent the most significant portion of the study.

5. The study also identified a number of factors that appear to be associated with the occurrence of the cases, including age, sex, and occupation.

6. The results of the study suggest that there is a need for further research in this area, particularly with regard to the factors identified in paragraph 5.

7. The study was conducted by the Department of Defense, Office of the Secretary of Defense, and the results are being provided to the Joint Chiefs of Staff for their review and consideration.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

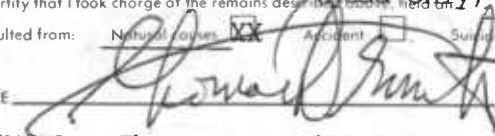

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |                     |  |  |  |            |  |
|---|--|---|--|--|--|--|--|---------------------|--|--|--|------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2b. DATE OF DEATH  |  | 2c. MONTH  |  | 2d. DAY             |  | 2e. YEAR                                     |  | 2f. HOUR   |  |
|   |  | MARTHA WALKER   |  | 5/21/84  |  |  |  |                     |  | 10:28 PM                                     |  |            |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS                              |  |            |  |
| FEMALE  |  | Black   |  | 5 14 1893  |  | 91 YRS.  |  | MONTHS              |  | DAYS   |  | HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                     |  |  |  |            |  |
| N. Carolina   |  | USA   |  |  |  | Baltimore, Md.   |  |                     |  |  |  | MD.        |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                     |  |  |  |            |  |
| Baltimore   |  | LUTHERAN HOSPITAL   |  |  |  |  |  |                     |  |  |  |            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS |  |  |  |            |  |
| md  |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  | 412 East 22nd St.   |  | 21218  |  |            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |                     |  |  |  |            |  |
| Theophilos  |  | Louise  |  |  |  |  |  |                     |  |  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  |                     |  |  |  |            |  |
| NO  |  | 218520269   |  | Mayville Harrison  |  | 412 E. 22nd Street   |  |                     |  |  |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |  |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |  |  |  |  |                     |  |  |  |            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                     |  |                     |  |  |  |            |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |                     |  |  |  |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                     |  |  |  |            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY              |  | STATE  |  |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>84</u> to <u>5/21</u> 19 <u>84</u> that (I) (we) lost<br>saw the deceased alive on <u>5/21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.          |  |   |  |  |  |  |  |                     |  |  |  |            |  |
| 22b. SIGNATURE<br><u>L. C. MURPHY</u>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><u>5/24/84</u>   |  |                     |  |  |  |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>L. C. MURPHY</u>  |  | 22e. ADDRESS<br><u>LUTHERAN HOSPITAL</u>  |  |  |  |  |  |                     |  |  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>BURIAL</u>  |  | 23b. DATE<br><u>5/26/84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Cemetery</u>  |  | 23d. LOCATION<br>CITY OR TOWN <u>Baltimore,</u> COUNTY <u>Md.</u> STATE <u>Md.</u> |  |                     |  |  |  |            |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                     |  |  |  |            |  |
| Wm C March F/H Inc.   |  | 1101 E North Ave.   |  | MAY 23 1984  |  | Julia Davidson-Randall   |  |                     |  |  |  |            |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |                  |   |  |   |  | REG. NO. 3508   |  |
|---|-------------------------|---|---|---|------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel Walker</b>  |                         |   |   |   |                  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>5-29 1984</b> |  | 2b. HOUR <b>M</b>   |  |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 17 1917</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>66</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD <b>5-29 1984</b>   |  | 2d. HOUR <b>3:52</b> P.M.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  | 13e. STREET ADDRESS<br><b>2235 Lamley St. 21231</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Walker</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola Alger</b>   |                  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |   |   | 16b. SOCIAL SECURITY NO.<br><b>214-12-7555</b>  |                  | 17. INFORMANT ADDRESS<br><b>Norwich, Conn.<br/>Harry Souers 365 Hamilton Ave.</b>                               |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |   |   |   |                  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                  |   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                       |  |   |  |
| 20d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         |   |   | 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  |   |  | 20f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>   |                         |   |   | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |                  |   |  | DATE SIGNED<br><b>5-30-84</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |                         |   |   | ADDRESS<br><b>111 Penn Street</b>   |                  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         |   |   | 23b. DATE<br><b>6/2/84</b>  |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Luth Cem.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Md.</b> |  |
| 24. FUNERAL DIRECTOR NAME<br><b>B. Dabrowski &amp; Son</b>  |                         |   |   |   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |
| ADDRESS<br><b>2818 E. Baltimore St.</b>   |                         |   |   |   |                  |   |  |   |  |   |  |



19312.00

19312

*[Handwritten signature and scribbles]*



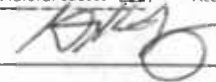
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13509

|   |  |                                     |  |  |  |  |  |   |  |   |  |   |  |
|---|--|-------------------------------------|--|--|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>Willotta  |  | MIDDLE<br>Walker   |  | LAST<br>Walker  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br>5/11/84 19       |  | 2b. HOUR<br>M<br>1:15<br>P M                              |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 1 33   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>50 YRS.            |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE<br>PRONOUNCED<br>DEAD<br>5/11/84 19                |  | 7d. HOUR<br>M<br>1:15<br>P M                              |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>N. Carolina   |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3212 Walbrook Ave., Apt. 3 |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                      |  |
| 13a. STATE<br>Maryland  |  |                                     |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>21216<br>3700 1/2 Clifton Avenue     |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charlie Thomas  |  |                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Easter Henderson  |  |  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                                     |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT<br>ADDRESS<br>Easter Thomas 2908 Ellicott Drive   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br>lying cause last.  |  |                                     |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Alcoholism</u>  |  |                                     |  |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                                     |  | 21b. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above. PARTIAL Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                     |  |  |  |  |  |   |  |   |  |   |  |
| ACTUAL<br>SIGNATURE<br>  |  |                                     |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |  |  | DATE<br>SIGNED 5/12/84  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |  |                                     |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |                                     |  | 23b. DATE<br>5/18/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.   |  |                                     |  | ADDRESS<br>1101 E North Avenue   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1984  |  |   |  |   |  |
|   |  |                                     |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |   |  |   |  |   |  |

SECRET  
U.S. GOVERNMENT PRINTING OFFICE  
1950 O-471-412



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 5 1 0  
REG. NO.

|   |  |   |   |   |                                   |
|---|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MIRIAM B WALLACE</b>                               |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>14</b> YEAR <b>84</b>                                |   | 2b. HOUR<br><b>5:45 AM</b>        |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>11</b> YEAR <b>29</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                 |                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>MD</b>                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>                   |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore City</b> 13c. CITY OR TOWN <b>Baltimore</b> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3113 Milford Ave. 21207</b>  |                                   |
| 14. FATHER'S NAME<br>FIRST <b>CRESTON</b> MIDDLE <b>Y</b> LAST <b>WOJNOST</b>             |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ELSIE</b> MIDDLE <b>Peterson</b> LAST                      |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>UNK</b>           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>214-26-2222</b>  |   | 17. INFORMANT<br><b>(CHART)</b>                                   |                                   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5722</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b> |
| IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>   |  | <b>1 hr.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION</b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>END STAGE LIVER DISEASE</b>   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                           |  | <b>3 MONTHS</b>   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **HEPATIC ENCEPHALOPATHY**

|                        |  |  |   |
|------------------------|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|---|

|  |  |  |  |
|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |

22a. I certify that (I) (this hospital) attended the deceased from **5/1**, 19 **84**, to **5/14**, 19 **84**, that (I) (we) last saw the deceased alive on **5/13**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|  |                     |  |                                    |
|--|---------------------|--|------------------------------------|
| 22b. SIGNATURE<br><b>JONATHAN SCHREIBER, MD</b>                    | DEGREE<br><b>MD</b> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>5/14/84</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JONATHAN SCHREIBER</b> |                     | 22e. ADDRESS<br><b>22 S. GREENE ST. 21201</b>  |                                    |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> | 23b. DATE<br><b>5/18/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carver Memorial</b> | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |
|--|-----------------------------|--|---|

|  |   |   |
|--|---|---|
| 24. FUNERAL DIRECTOR<br>NAME <b>The Family Funeral Home</b> ADDRESS <b>1348 N. Calhoun</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1984</b> | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodriguez</b> |
|--|---|---|

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 1 3 5 1 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WILSON - MARTIN WALLACE |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 27 84                                  |   | 2b. HOUR<br>11:20P <sub>M</sub>           |
| 3 SEX<br>MALE  | 4 RACE<br>BLACK  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 8 23   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA                      | 7b. CITIZEN OF WHAT COUNTRY?<br>US   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, MARYLAND (CITY) MD. |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, BALTIMORE, MARYLAND 21218 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISABLED |   | 12b. KIND OF BUSINESS OR INDUSTRY         |

|   |  |                          |   |  |   |   |
|---|--|--------------------------|---|--|---|---|
| 13a. STATE<br>MARYLAND  |  |                          | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1010 W. BALTIMORE ST. 21223 |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WILSON M. WALLACE  |  |                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MABLE |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES |  | 16b. SOCIAL SECURITY NO. |   | 17 INFORMANT ADDRESS<br>RONALD WALLACE 2255 REISTERSTOWN RD. 21216 |   |   |

|   |  |  |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Transferral Cell Ca of Renal Pelvis</i><br><i>1891</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>metastatic to lung</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2/84 - dx'd</i> |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is

|  |   |  |  |
|--|---|--|--|
| 19a. DATE OF OPERATION<br><i>2/84</i>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Nephrectomy - palliation</i> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/22</i> 19 <i>84</i> to <i>5/27</i> 19 <i>84</i> that (I) (we) last saw the deceased alive on <i>5/27</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br><i>Mary G. Bolton</i>  |   | DEGREE<br><i>MD</i>  | 22c. DATE SIGNED<br><i>5/27/84</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARY G. BOLTON  |   | 22e. ADDRESS<br>22 S. Greene St. Balto. Md 21205                                     |  |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>                        | 23b. DATE<br><i>5-31-84</i> | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FORREST VET. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GARRISON MARYLAND |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>E.L. PHILLIPS 1721 N. MONROE ST. |                             | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 29 1984</i>         | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                                       |  |  | REG. NO. 13512   |                             |
|---|--|---|---------------------------------------|--|--|--|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>TORRENCE R. WALSTON</b>  |  |   |                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MAY 21, 1984</b>  |  | 2b. HOUR<br><b>11:45P M</b> |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 14, 1948</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1707 BLOOMINGDALE ROAD</b>                  |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNEMPLOYED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b> | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM WALSTON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELMERIE LEOLA COLLINS</b>   |                                       |  |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 74 7766</b>  |                                       | 17. INFORMANT<br>ADDRESS<br><b>MRS. ELMERIE L. BERRY 1707 BLOOMINGDALE RD.</b>   |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1509</b> IMMEDIATE CAUSE (a) <b>METASTATIC CANCER OF ESOPHAGUS.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                                       |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b>                |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |                                       |  |  |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |                                       |  |  |  |                             |
| 22b. SIGNATURE<br><i>Martin A. Yahihiro</i>   |  |   |                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/23/84</b>   |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN A. YAHIRO, M.D.</b>  |  |   |                                       | 22e. ADDRESS<br><b>600 N. WOLFE ST BALTIMORE MD 21205</b>  |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>5/26/84</b>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LONG GREEN (BALTO.) MD.</b> |                             |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE</b>  |  |   |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Fuka Davidson-Randall</i>                   |                             |

BP

11:45 PM MAY 27, 1964

WASHINGTON

MEMORANDUM



TO :

FROM :

SUBJECT :

35

X

BALTIMORE CITY

US OF A

REMARKS

1707 BLOOMINGDALE ROAD

BALTIMORE

UNRECORDED

1707 BLOOMINGDALE RD. 21316

X

BALTIMORE

REMARKS

COLLINS

LEVIN

ELDER

WILSON

WILSON

214 74 7500 MRS. EDWARD E. BERRY 1707 BLOOMINGDALE RD.

NO

X

JOHN GIBSON (PHOTO) ET.

ET. ELM. GIBSON

2/25/64

DOUGLAS

15:27 PARK HEIGHTS VARIATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8413513  
REG. NO.FOR  
1 - STATE  
REGISTRAR

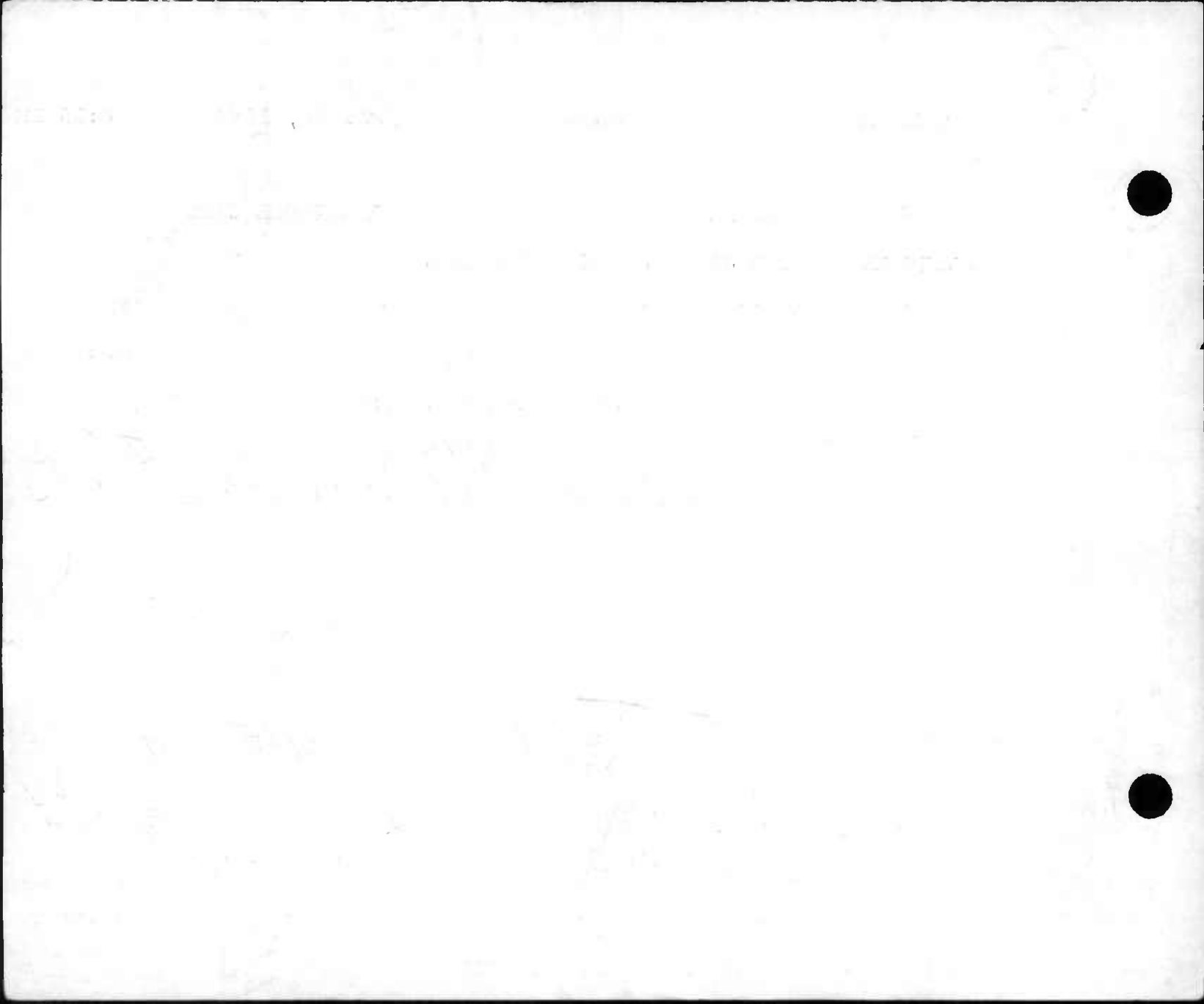
|  |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THERESA MARYANN WALTHER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 15, 1984</b>             |   | 2b. HOUR<br><b>6:15 PM</b>   |   |  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/10/1928</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                             |  | 8. IF UNDER 24 HRS.                          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>51 BROADSHIP ROAD 21222</b>         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ADAM J. WENERSKI</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVA RAKOWSKI</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214.22.8282</b>  |  | 17. INFORMANT<br><b>CHARLES E. WALTHER</b>  |  |  |  | ADDRESS<br><b>SAME AS 13e.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4300 IMMEDIATE CAUSE (a) Cerebral infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>subarachnoid hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>8 days</b><br><b>9 days</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11/84</b> 19 <b>84</b> to <b>5/15/84</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/11/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C. Borel, M.D.</b>  |  |  |  |   |  | DEGREE<br><b>CECIL BOREL, M.D.</b>  |  |  | 22c. DATE SIGNED<br><b>5/15/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CECIL BOREL, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hosp.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  |  | 23b. DATE<br><b>5/16/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>  |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 17 1984</b>  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 84 13514  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY A. LAST WAITZ   |  |  |  | 2a. DATE OF DEATH MONTH 5 DAY 21 YEAR 84   |  | 2b. HOUR 3 A.M.   |  |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH July DAY 25 YEAR 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J. L. DEATON MEDICAL CENTER Balto. Md.          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 13a. STATE Maryland   |  | 13b. COUNTY -----  |  | 13c. CITY OR TOWN Baltimore  |  | 13e. STREET ADDRESS / ZIP CODE 127 E. Fort Ave. Balto. Md. 21230  |  |
| 14. FATHER'S NAME FIRST William MIDDLE ----- LAST Holland   |  | 15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Bell LAST Holland   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |   |  |
| 16b. SOCIAL SECURITY NO. 214-38-7926  |  | 17. INFORMANT Mrs Margaret L. Waltz, 114 E. Fort Ave. Balto. Md. 21230   |  | ADDRESS 21230  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) INTRACEREBRAL BLEED<br>4310<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MO.   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEIZURE DISORDER ; @ CVA   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16/84 to 5/21/84, that (we) lost saw the deceased alive on 5/21/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE M. P. DALY   |  | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 5/21/84   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. DALY   |  | 22e. ADDRESS 40 J. L. DEATON MEDICAL CENTER  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE May 23, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 21230   |  | 23d. LOCATION CITY OR TOWN Baltimore, Maryland STATE  |  |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Balto. Md.   |  | 25a. DATE REC'D. BY REGISTRAR MAY 22 1984  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

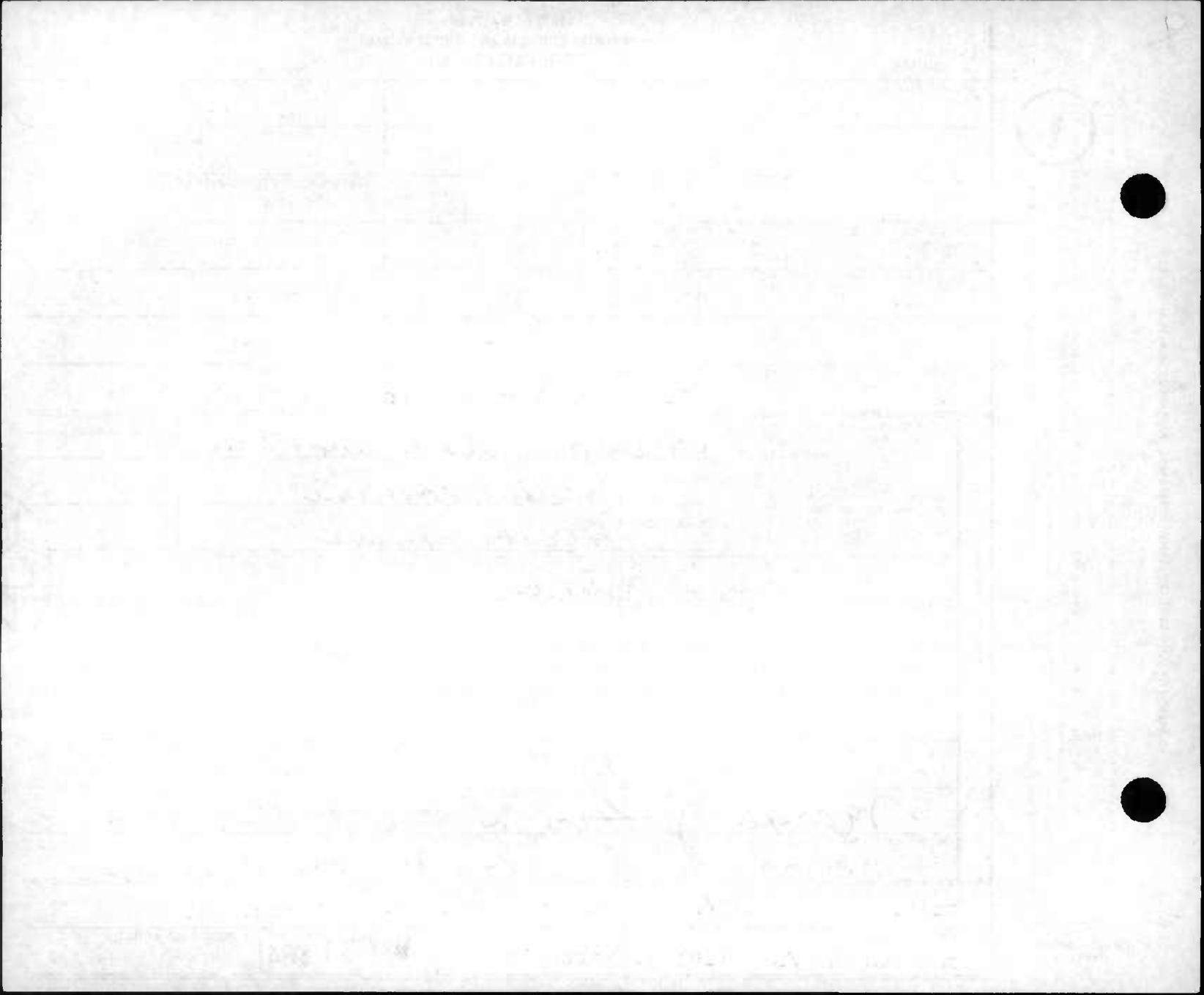
8413515

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FLORENCE WARD</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 26, 1984</b>            |   | 2b. HOUR<br><b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 28 20</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>2304 Wichita Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. STREET ADDRESS<br><b>2304 Wichita Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George E. Ward</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Addie Letitia</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-20-9224</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy Gross 2304 Wichita Avenue</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction + atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic coronary</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic coronary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>1629</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Myeloid</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-19</b> , 19 <b>84</b> , to <b>5-28</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Marsha J. Brown</b>   |   | DEGREE<br><b>N</b>  |   | 22c. DATE SIGNED<br><b>5-31-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARSHA J. BROWN</b>  |   | 22e. ADDRESS<br><b>8440 N. Carey Street 21417</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |   | 23b. DATE<br><b>6/1/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randall</b>  |   |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Pauline WARNER</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 31, 1984</b>   |  | 2b. HOUR<br><b>7:30am</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 13 25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>58</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2247 Aisquith St. 21218</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Scales</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Scales</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-22-9600</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Junior Warner 2247 Aisquith Street</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma with Cerebral metastasis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 17</b> , 19 <b>84</b> , to <b>May 31</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 31</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I/we) (did) (do not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>S. Ramani, M.D.</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/31/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAMESH SARAPATHI, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>6/4/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |

FILED

RECEIVED



RECEIVED

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

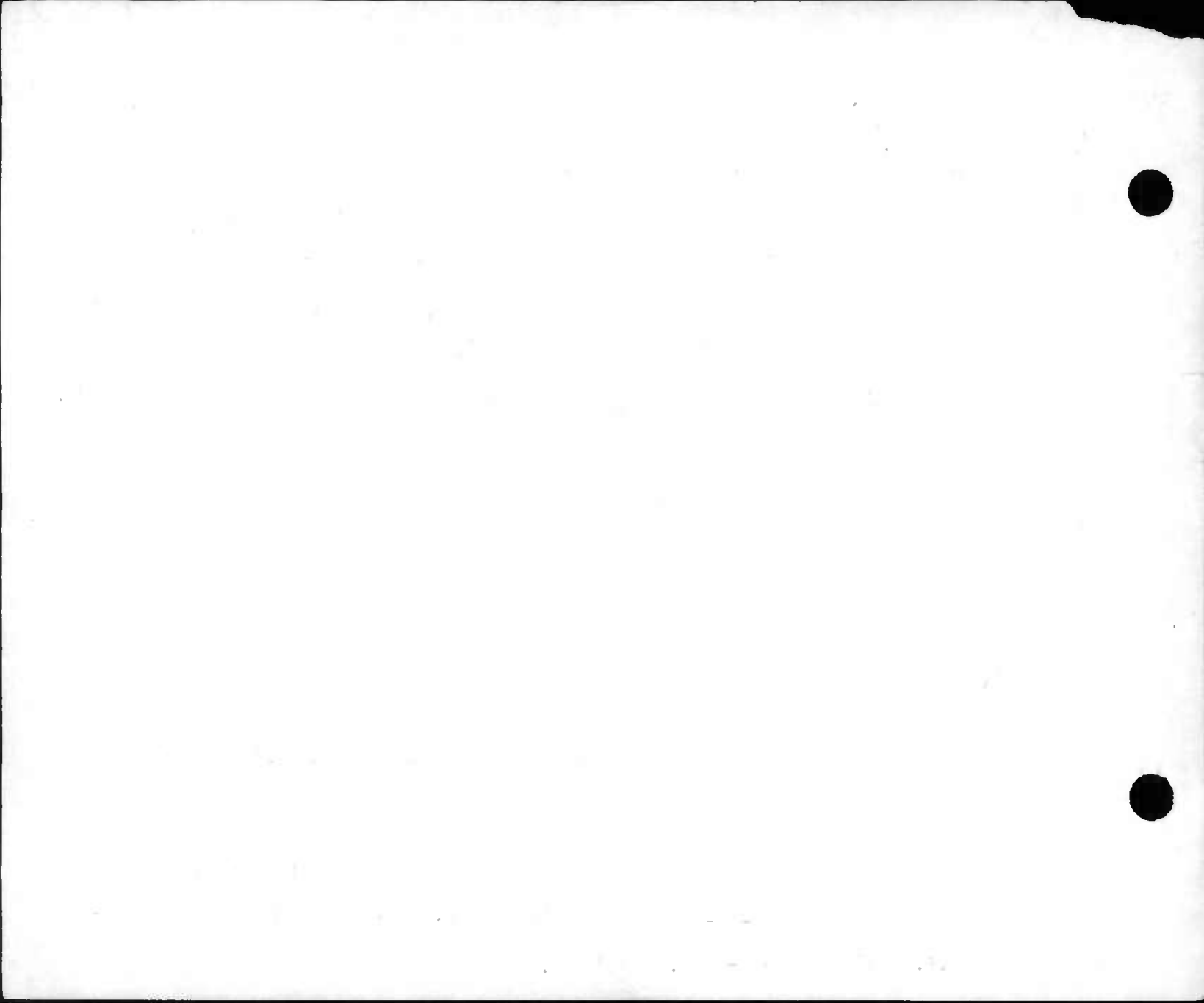
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 8  |  | 4  |  | 1   |  | 3  |  | 5  |  | 1  |  | 7 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  | 2b. HOUR                                     |  |   |  |
| FIRST MIDDLE LAST<br>JOHN ALFRED WASHINGTON  |  |  |  |  |  | MONTH DAY YEAR<br>5 19 84   |  |  |  |  |  | 1:00a M                                      |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |  |  |   |  |
| MALE   |  | BLACK  |  | MONTH DAY YEAR<br>1 18 29  |  | 55 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.   |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |  |  |   |  |
| GEORGIA  |  | US   |  |  |  | BALTIMORE CITY, MD.   |  |  |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |
| BALTIMORE  |  | VAMC 3900 LOCH RAVEN BLVD 21218  |  |  |  | DISABLED  |  |  |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |  |  |   |  |
| MARYLAND   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 515 BEAUMONT AVENUE 21212  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |  |  |   |  |
| FIRST MIDDLE LAST<br>JOHN WASHINGTON   |  |  |  | FIRST MIDDLE LAST<br>MILDRED BELL  |  |   |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |  |  |   |  |
| YES  |  |  |  | 253422523  |  | WILLIE ANN WASHINGTON 515 BEAUMONT AVE.                             |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |
| 5728 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| (b) <u>Liver + Kidney failure</u>  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| (c)  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| ETOH abrs  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |   |  |
|  |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |   |  |
|  |  |  |  | P.M. 19  |  |   |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |
|  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| 22. I certify that (X) (this hospital) attended the deceased from MAY 4 19 84 to MAY 19 19 84, that (X) (we) lost saw the deceased alive on MAY 19 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death. |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |   |  |
| Clark N. Celano M.D.   |  |  |  |  |  |   |  |  |  | 5/19/84  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |
| C. Celano M.D.   |  |  |  |  |  |   |  | 3900 LOCH RAVEN BLVD BALTO, MD 21218   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |
| BURIAL   |  |  |  | 5-22-84  |  | CROWNSVILLE VET. CEM.   |  | CROWNSVILLE MARYLAND   |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |   |  |
| E.L. PHILLIPS 1721-27 N. MONROE ST.  |  |  |  |  |  |   |  | MAY 23 1984  |  | [Signature]  |  |  |  |   |  |

BP



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. DIRECTIONS TO THE FUNERAL HOME: PAGES 1, 2, AND 3 TO THE FUNERAL HOME; PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF DEATH. IF THERE IS AN UNUSUAL OCCURRENCE, DIVISION OF VITAL RECORDS, 801 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |
| REG. NO. 3518  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ora LEE Washington</b>  |  |  |  |  |  |  |  |  |  |
| 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br><input type="checkbox"/> ESTI. <input checked="" type="checkbox"/> 5/11/84   |  |  |  |  |  |  |  |  |  |
| 2b. HOUR<br>M A P 29   |  |  |  |  |  |  |  |  |  |
| 3. SEX FEMALE  |  |  |  |  |  |  |  |  |  |
| 4. RACE BLACK  |  |  |  |  |  |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUN 8 1916</b>   |  |  |  |  |  |  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>67</b>  |  |  |  |  |  |  |  |  |  |
| IF UNDER 1 YR. IF UNDER 24 HRS.  |  |  |  |  |  |  |  |  |  |
| 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>5/12/84</b>  |  |  |  |  |  |  |  |  |  |
| 7d. HOUR<br>M A P 29   |  |  |  |  |  |  |  |  |  |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  |  |  |  |  |  |  |  |  |
| 7f. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  |  |  |  |  |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  |  |  |  |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1528 W. Lanvale St.</b>  |  |  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  |  |  |  |  |  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FULLER PRODS.</b>  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  |  |  |  |  |  |  |
| 13b. COUNTY  |  |  |  |  |  |  |  |  |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  |  |  |  |  |  |  |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 13e. STREET ADDRESS<br><b>1528 W. LANVALE ST 21217</b>   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOSHUA CHEEK</b>   |  |  |  |  |  |  |  |  |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ROBERTA BROOKS</b>  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  |  |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>216 34 8742A</b>  |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT ADDRESS<br><b>MR. BOOKER T. WASHINGTON 3 KAERN DR.</b>   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |  |  |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b> TITLE (SPECIFY) <b>Assistant MEDICAL EXAMINER</b> DATE SIGNED <b>5/13/84</b>   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b> ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  |  |  |  |  |  |  |  |
| 23b. DATE <b>5/17/84</b>   |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>  |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE (BALTO.) MD.</b>   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE</b>  |  |  |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1984</b>   |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>   |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8413519  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEONARD William WATKINS</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 26 84</b>   |  | 2b. HOUR<br><b>605A</b>   |  |
| 3. SEX<br><b>MALIE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 22 93</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA/MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSP</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>PRINCE GEORGE</b>   |  | 13c. CITY OR TOWN<br><b>PRINCE GEORGE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS WATKINS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY RANDALL</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-14-2363</b>  |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>MARIE W. LAYTON 1216 N. LONGWOOD</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>dysphagia / general debilitation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bilateral pleural effusions</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Sacral decubiti</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/17 1984</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>84</b> , to <b>5/26</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  | 22b. SIGNATURE<br><b>R. Fold</b>  |  | 22c. DATE SIGNED<br><b>5/26/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Fold</b>  |  | 22e. ADDRESS<br><b>Lutheran Hosp. 13th Street Balto MD</b>  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5-31-84</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEM</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TSARTO MD</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOSEPH L. RUSS 22224 NORTH AVE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |   |  |   |  |

BP

STANDARD TIME

11



11/11/11

11/11/11

11/11/11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3520

|  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
|--|---------|--|--|---|--------------------------|---|------------------|-----------------------------------|--------------------------------------|-------------------------------|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  |  |   |                          |   |                  |                                   |                                      | 2a. DATE KNOWN OF DEATH       |          | 2b. HOUR                                     |  |
| John L. Watson   |         |  |  |   |                          |   |                  |                                   |                                      | X MONTH DAY YEAR<br>5 4 19 84 |          | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.           |   | IF UNDER 24 HRS. |                                   | 2c. DATE PRONOUNCED DEAD             |                               | 2d. HOUR |  |  |
| M  | W       | 8/14/35  |  | 48 YRS.   | MONTHS DAYS HOURS MIN.   |   |                  |                                   | 5 4 19 84                            |                               | 4:26P    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  |   | 8. MARRIED               |   | NEVER MARRIED    |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH |                               |          |  |  |
| S.C.   |         | USA  |  |   | WIDOWED                  |   | DIVORCED         |                                   | Baltimore City, MD.                  |                               |          |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |   |                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                  | 12b. KIND OF BUSINESS OR INDUSTRY |                                      |                               |          |  |  |
| Baltimore  |         | 1601 S. Highland   |  |   |                          | MECHANIC  |                  |                                   |                                      |                               |          |  |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?  |                  | 13e. STREET ADDRESS               |                                      |                               |          |  |  |
| MD.  |         | BALTO  |  | ESSEX   |                          | YES NO  |                  | 45 PELCAR AVE                     |                                      | 21221                         |          |  |  |
| 14. FATHER'S NAME  |         |  |  |   | 15. MOTHER'S MAIDEN NAME |   |                  |                                   |                                      |                               |          |  |  |
| WILLIAM WATSON   |         |  |  |   | UNK                      |   |                  |                                   |                                      |                               |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |  |  | 16b. SOCIAL SECURITY NO.                                    |                          | 17. INFORMANT   |                  |                                   | ADDRESS                              |                               |          |  |  |
| UNK  |         |  |  | 248 50 1158   |                          | MADELINE WATSON   |                  |                                   | ABOVE                                |                               |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| IMMEDIATE CAUSE (a) Asphyxia   |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| DUETO, OR AS A CONSEQUENCE OF  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| (b) Compression of chest and abdomen   |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| DUETO, OR AS A CONSEQUENCE OF  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| (c)  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                          |   |                  |                                   |                                      | 20. AUTOPSY?                  |          |  |  |
|  |         |  |  |   |                          |   |                  |                                   |                                      | YES X NO                      |          |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                  |                                   |                                      |                               |          |  |  |
|  |         |  |  | 4:10M 5 4 19 84   |                          | Subject pinned by forklift  |                  |                                   |                                      |                               |          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK X NOT WHILE AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                          | 21f. LOCATION   |                  | CITY OR TOWN                      |                                      | COUNTY                        |          | STATE  |  |
|  |         |  |  | garage  |                          | 1601 S. Highland  |                  | Balto.                            |                                      |                               |          | Md.  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident X, Suicide, Homicide, Undetermined manner. |         |  |  |   |                          |   |                  |                                   |                                      |                               |          |  |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |                          |   |                  | DATE SIGNED                       |                                      |                               |          |  |  |
| Thomas D. Smith, M.D.  |         |  |  | M.D. Deputy Chief   |                          |   |                  | 5/5/84                            |                                      |                               |          |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |                          |   |                  |                                   |                                      |                               |          |  |  |
| Thomas D. Smith, M.D.  |         |  |  | 111 Penn St. Balto., MD.                                    |                          |   |                  |                                   |                                      |                               |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |                  | 23d. LOCATION                     |                                      | COUNTY                        |          | STATE  |  |
| BURIAL   |         |  |  | 5/7/84  |                          | HOLLY HILL  |                  | BALTO                             |                                      |                               |          | MD.  |  |
| 24. FUNERAL DIRECTOR   |         |  |  | 25a. DATE REC'D. BY REGISTRAR                               |                          |   |                  | 25b. REGISTRAR'S SIGNATURE        |                                      |                               |          |  |  |
| J. G. CONNELLEY  |         |  |  | 300 MACE  |                          |   |                  | MAY 14 1984                       |                                      | Julia Davidson-Randall        |          |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE "CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FOUR YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

Items 18-22a 7/26/84 mth P#593

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3521

|  |  |         |                   |   |  |                                 |  |  |                |                  |  |  |  |           |  |
|--|--|---------|-------------------|---|--|---------------------------------|--|--|----------------|------------------|--|--|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST |   |  | 2a. DATE KNOWN OF DEATH         |  |  | MONTH DAY YEAR |                  |  | 2b. HOUR   |  |           |  |
| Mary   |  |         | L. Watson         |   |  | 5 20 1984                       |  |  |                |                  |  | M  |  |           |  |
| 3. SEX   |  | 4. RACE |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YR.   |                | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR  |  |
| Female   |  | Black   |                   | 7 17 49   |  | 34 YRS.                         |  | MONTHS DAYS  |                | HOURS MIN.       |  | 5 21 1984  |  | 6:55 a.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |           |  |
| Virginia   |  |         |                   | U.S.A.  |  |                                 |  |  |                |                  |  | Baltimore City MD.   |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |           |  |
| Baltimore  |  |         |                   | 1035 Orleans Street   |  |                                 |  |  |                |                  |  |  |  |           |  |
| 13a. STATE   |  |         |                   | 13b. COUNTY   |  |                                 |  | 13c. CITY OR TOWN  |                |                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |           |  |
| Maryland   |  |         |                   |   |  |                                 |  | Baltimore  |                |                  |  | 13e. STREET ADDRESS  |  |           |  |
|  |  |         |                   |   |  |                                 |  |  |                |                  |  | 1035 Aisquith St. 21202  |  |           |  |
| 14. FATHER'S NAME  |  |         |                   | 15. MOTHER'S MAIDEN NAME  |  |                                 |  |  |                |                  |  |  |  |           |  |
| James  |  |         |                   | Gary  |  |                                 |  | Mary   |                |                  |  |  |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |                   | 16b. SOCIAL SECURITY NO.  |  |                                 |  | 17. INFORMANT  |                |                  |  | ADDRESS  |  |           |  |
| NO   |  |         |                   |   |  |                                 |  | Mary Gary  |                |                  |  | 1744 N. Chester Street   |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>3030 IMMEDIATE CAUSE (a) <u>Alcoholism</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause <u>lost</u> .<br>(b) _____<br>(c) _____   |  |         |                   |   |  |                                 |  |  |                |                  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |         |                   |   |  |                                 |  |  |                |                  |  |  |  |           |  |
| 19a. DATE OF OPERATION   |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                 |  |  |                |                  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                |                  |  |  |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                |                  |  |  |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |                   |   |  |                                 |  |  |                |                  |  |  |  |           |  |
| ACTUAL SIGNATURE   |  |         |                   | TITLE (SPECIFY)   |  |                                 |  | DATE SIGNED  |                |                  |  |  |  |           |  |
| Margarita A. Korell, M.D.  |  |         |                   | Assistant   |  |                                 |  | 5/21/84  |                |                  |  |  |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |                   | ADDRESS   |  |                                 |  |  |                |                  |  |  |  |           |  |
| Margarita A. Korell, M.D.  |  |         |                   | 111 Penn St. Balto., MD.  |  |                                 |  |  |                |                  |  |  |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |                   | 23b. DATE   |  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY   |                |                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |           |  |
| BURIAL   |  |         |                   | 5/25/84   |  |                                 |  | Mount Auburn Cem.  |                |                  |  | Baltimore, Md.   |  |           |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |                   | ADDRESS   |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR  |                |                  |  | 25b. REGISTRAR'S SIGNATURE   |  |           |  |
| Wm C March F/H Inc.  |  |         |                   | 1101 E. North Ave   |  |                                 |  | MAY 22 1984  |                |                  |  | Davidson-Randall   |  |           |  |

BP 711



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 13522

|  |  |  |   |   |  |  |                               |   |   |  |
|--|--|--|---|---|--|--|-------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret Rosella Weamer   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 21, 1984 |   |  | 2b. HOUR<br>M  |                               |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 5, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS.                                  |                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                               |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House wife |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                       |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland |  |  |   |   | 13b. COUNTY Anne Arundel   |  | 13c. CITY OR TOWN Glen Burnie |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Prough  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jessie Forester |  |                               |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |   | 17. INFORMANT (son)<br>Mr. Cyril P. Weamer  |  | ADDRESS<br>Same as # 13  |                               |   |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic vascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 yrs</u><br><u>15 yrs</u> |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 22</u> 19 <u>80</u> to <u>May</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>May 2</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Justinas Kudirka</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |  |  | 22c. DATE SIGNED<br>5.21.84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Justinas Kudirka   |  |  |  | 22e. ADDRESS<br>3927 Annapolis Rd.<br>Baltimore, Md.                           |  |  |  |

|  |  |                           |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 23, 1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Altoona Blair Pennsylvania |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>R. H. Hopkins<br>ADDRESS<br>Singleton Funeral Home, Glen Burnie, Md. |  |                           |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984           |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>                    |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 4 1 3 5 2 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**George C. Webb**

2a. DATE OF DEATH MONTH DAY YEAR  
**5-08-84** 2b. HOUR  
**4:15 A.M.**

3. SEX  
**Male** 4. RACE  
**Black** 5. DATE OF BIRTH MONTH DAY YEAR  
**12-15-04** 6. AGE (IN YEARS (LAST BIRTHDAY))  
**79** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**North Carolina** 7b. CITIZEN OF WHAT COUNTRY?  
**USA** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH  
**Baltimore City** MD.

10. CITY OR TOWN OF DEATH  
**Baltimore** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Bon Secours Hospital** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Retired from Beth. Steel** 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE  
**Md.** 13b. COUNTY  
**—** 13c. CITY OR TOWN  
**Baltimore** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE  
**3906 Gelston Drive 21229**

14. FATHER'S NAME FIRST MIDDLE LAST  
**William — Webb** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Lula — Slade**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**NO** 16b. SOCIAL SECURITY NO.  
**240-09-1398** 17. INFORMANT ADDRESS  
**Margaret O. Webb 3906 Gelston Drive**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
**4280** IMMEDIATE CAUSE (a) **Renal Failure.**  
DUE TO, OR AS A CONSEQUENCE OF (b) **C.H.F.**  
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

**Heart Arrhythmia**

19a. DATE OF OPERATION  
**5-5-84** 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
**Arrhythmia** 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
**—** 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**— P.M. 1984** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  
**—**

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
**—** 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
**— — — —**

22a. I certify that (I) (this hospital) attended the deceased from **5-5-84**, to **5-8-84**, that (I) (we) last saw the deceased alive on **5-7-84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
**A. J. D. H.** DEGREE **MD** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED  
**5/10/84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**AJ D H** 22e. ADDRESS  
**5216 Guyton Rd. Columbia Md.**

23a. BURIAL, CREMATION, REMOVAL  
**BURIAL** 23b. DATE  
**5/12/84** 23c. NAME OF CEMETERY OR CREMATORY  
**Arbutus Memorial Pk** 23d. LOCATION CITY OR TOWN COUNTY STATE  
**Arbutus, — — — Md.**

24. FUNERAL DIRECTOR NAME ADDRESS  
**Wm C March F/H Inc. 1101 E North Avenue** 25a. DATE REC'D. BY REGISTRAR  
**MAY 10 1984** 25b. REGISTRAR'S SIGNATURE  
**J. H. Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



IRCB

BOMB

*[Faint, illegible text and markings covering the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   |
|--|--|--|--|---|--|--|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 8 4 1 3 5 2 4<br>REG. NO.  |  |   |  |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CATHARINE WEBER   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 20 1984   |  | 2b. HOUR<br>0400 M   |   |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 19 1891   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House keeping  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home Keeper   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |  |   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Kingsville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>6905 Beech Ave. 21206  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Weber  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Saffran   |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-50-7792   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Charles Weber, Kingsville, Md. 21087   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PRESUMED LOUS MALIGNANCY.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no  |  |  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 17 19 84 to MAY 20 19 84, that (I) (we) last saw the deceased alive on MAY 20 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br>M. Keith Rawlings MD   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5-20-84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. KEITH RAWLINGS, MD   |  |  |  |   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>5-23-1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Balto. City Maryland   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Kingsville, Md. 21087  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendall   |   |

BP

2211

DATE \_\_\_\_\_

100% of the total population of the United States.

## Introduction

703

• 7-10-1986



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 1 3 5 2 5

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James WESLEY WEBSTER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 19 84</b>                                  |   | 2b. HOUR<br><b>5:00 PM</b>                           |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>cauc.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 17 10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LITHOGRAPHER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRINTING</b> |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES WEBSTER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MOLLIE UNKNOWN</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-0024A</b>   |   | 17. INFORMANT <b>MRS. SARAH WEBSTER</b><br><b>5610 WINNER AVE. BALTO., MD 21215</b>             |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hypotension</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiac failure and myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>coronary artery disease</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>1 hour</b><br><b>several years</b> |
|--|--|---|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110   |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Richard A Berg</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>5/21/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A Berg</b>  |  | 22e. ADDRESS<br><b>Suite 400; 711 W 40th St, Baltimore, Md 21211</b>   |  |

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>MAY 22, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>           | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>             |

SECRET  
OFFICE OF THE DIRECTOR  
CENTRAL INTELLIGENCE AGENCY



CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 13526  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Kenneth</u> MIDDLE <u>Lee</u> LAST <u>Webster</u><br><u>KENNETH L WEBSTER</u>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>5</u> <u>21</u> <u>84</u>  |  | 2b. HOUR<br><u>5:14</u> M   |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>08</u> <u>16</u> <u>05</u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>N.-C.-G.-H.</u> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.   |  |
| 13a. STATE<br><u>MD</u>   |  | 13b. COUNTY<br><u>U.S.</u>  |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Samuel</u> <u>L</u> <u>Webster</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Anna</u> <u>L</u> <u>No Elwee</u>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Sheet Metal Worker</u>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>UNKNOWN</u> <u>No</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>213 -07-4675</u>   |  | 17. INFORMANT<br><u>WIFE</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>0389</u> IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 DAYS</u><br><u>4 DAYS</u>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>CORONARY ARTERY DISEASE</u>  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>8 PM</u> <u>8</u> <u>21</u> <u>84</u>                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> , 19 <u>84</u> , to <u>5/21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |  |   |  |
| 22b. SIGNATURE<br><u>DR. IGOR SIMON</u>   |  | DEGREE<br><u>M.B.B.S.</u>   |  | 22c. DATE SIGNED<br><u>5/21/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |
| <u>DR. IGOR SIMON</u>   |  | <u>C/O N.-C.-G.-H.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>May 24, 1984</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral</u>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore</u> <u>Maryland</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 22 1984</u>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Leonard J. Ruck, Inc. Baltimore, Maryland</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |                              |  |   |  |
|--|--|--|---|--|--|---|------------------------------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 84 REG. NO. 13527  |   |  |  |   |                              |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |   |  | 2a. DATE OF DEATH  |   |                              | 2b. HOUR   |   |  |
| JENNIE WEED  |  |  |   |  | MAY 19, 1984   |   |                              | M  |   |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                              | IF UNDER 1 YEAR  |   |  |
| Female   |  | White  |   | June 28, 1886  |  | 97 YRS.   |                              | MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                              |  |   |  |
| Canada   |  | USA  |   |  |  | Baltimore City MD.  |                              |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                              | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Baltimore  |  | Meridian Nursing Center  |   |  |  | Seamstress  |                              | Dept. Store  |   |  |
| 13a. STATE   |  |  |   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN            |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |   |  | Baltimore  |   | Baltimore                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME   |   |                              |  |   |  |
| William Jeffrey  |  |  |   |  | Loretta Falon  |   |                              |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |   |                              |  |   |  |
| No   |  |  | 212-10-4178   |  | Marie W. Kamtman Same  |   |                              |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CVA</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |  |  |   |  |  |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 weeks</u>      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |  |  |   |                              |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                              |  |   |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |  |  |   |                              |  |   |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |   |                              |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |   |                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>1984</u> to <u>May 19</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |   |  |  |   |                              |  |   |  |
| 22b. SIGNATURE   |  |  |   |  | DEGREE   |   |                              | 22c. DATE SIGNED   |   |  |
| <u>I.W. Fromm, M.D.</u>  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                              | 5/21/84  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22e. ADDRESS   |   |                              |  |   |  |
| I.W. Fromm, M.D.   |  |  |   |  | 8014 Harford Rd. Balto., Md. 21234   |   |                              |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION                |  |   |  |
| Cremation  |  |  | May 21, 1984  |  | Greenmount   |   | Baltimore city, Maryland     |  |   |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  |  |   |  | MAY 22 1984  |   | <u>Lila Davidson-Randell</u> |  |   |  |

LIBER

NOV 19 1964

NOV 19 1964

1. The first part of the report deals with the general situation in the country. It is a very interesting and informative study of the country's development since independence. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation. It is a very detailed and comprehensive study of the country's economy. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's economy.

3. The third part of the report deals with the social situation. It is a very detailed and comprehensive study of the country's social structure. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's social structure.

4. The fourth part of the report deals with the political situation. It is a very detailed and comprehensive study of the country's political system. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's political system.

5. The fifth part of the report deals with the cultural situation. It is a very detailed and comprehensive study of the country's culture. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's culture.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | REG. NO. 8413528   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lydia Weeks</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>22</b> YEAR <b>84</b>                |  | 2b. HOUR<br><b>1:50 A.M.</b>   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>10</b> YEAR <b>10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSP</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HSWE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>—</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>JAMES</b> MIDDLE <b>BOWFER</b> LAST <b>LAST</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNK</b> MIDDLE <b>—</b> LAST <b>—</b>      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>148105383</b>                                    |  | 17. INFORMANT<br>ADDRESS <b>13218 GUNDALE AVE.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>any</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>atherosclerosis coronary vessels disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>1) diabetes mellitus mellitus ~ chronic lung disease</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>B. Brander</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/22/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. Brander</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Mercy Hospital, St Pauls Balto Md 21202</b>                  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>5/25/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                           |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MACE</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

BP \_\_\_\_\_

A

2025 COTTON

CHIEF



2025 COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |  |  |   |  | REG. NO. 3 5 2 9  |  |   |  |
|---|--|------------------|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>William Gustavus Weitzel   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>5-10 19 84 |  | 2b. HOUR<br>M<br>1:47 P.M.  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 14 95  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br>88                  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-10 19 84  |  | 7d. HOUR<br>P.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3215 Fleet Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Elect. Eng.  |  |   |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3215 Fleet Street 21224  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Washington Weitzel  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Thompson   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 1<br>215-01-8446  |  | 17. INFORMANT ADDRESS<br>John R. Weitzel 4108 Brendan Ave. 21213 |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>5-11-84  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street  |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>5-12-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart Cemetery      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk, Balto. Co. Md.                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Charles S. Zeiler & Son Inc. 901 S. Conkling St   |  |                  |  |   |  |  |  |   |  |   |  |   |  |

MAY 11 1984  
REC'D BY REG. CLERK  
FILED IN REG. CLERK'S OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 84 13530 REG. NO.   |  |   |  |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY WEKSLER   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 10 84   |   |   | 2b. HOUR<br>4:00A  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 18 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 86XXX YRS.                          |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USSRUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY OF BALTIMORE MD.             |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSP |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   | 13b. COUNTY  |   | 13c. CITY<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3807 Clark Lane       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AARON   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROSE UNKNOWN          |   |  | ADDRESS (21209)   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-32-9850 |   | 17. INFORMANT<br>DR. WILBUR S. WEKSLER 2219 FARRINGTON RD.   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE STROKE<br>4360 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4, 19 84, to 5/10, 19 84, that (I) (we) lost saw the deceased alive on 5/9, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>J. YOUNG  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br>5/10/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. YOUNG   |  |   |  |   | 22e. ADDRESS<br>SINAI HOSP OF BALTO  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   | 23b. DATE<br>5/11/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO CEM   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>SO L LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  |   |  |   | 25. DATE REC'D BY REGISTRAR<br>MAY 15 1984   |   |   |  |  |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell                      |   |  |  |  |

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 5 3 1

REG. NO.

1 - FOR  
STATE  
REGISTER

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAULINE WELCH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 11, 1984</b>                          |   | 2b. HOUR<br><b>8:30</b> M   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 - 25 - 1909</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.<br>MONTHS DAYS HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.           |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md</b>   |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Dobbins</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Racheal Grayson</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-16-2335A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Ronald Floyd S/A</b>                         |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>20 hours.</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____  |  |   |

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |   |  |  |
|--|---|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 MAY</b> 19 <b>84</b> to <b>11 MAY</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11 MAY</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br><b>Alison Freifeld</b>   |   | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>5/11/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALISON FREIFELD</b>  |   | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO. MD 21205</b><br><b>JOHNS HOPKINS HOSPITAL, BALTO., MD</b> |  |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>5-17-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville VACn</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brown-Thompson F.H.</b>    |                             | ADDRESS<br><b>1913 W. Balto. St.</b>                          | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 18 1984</b>                  |
|   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>         |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please attach to the funeral papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

44



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial record. If permitted, then please remove the burial record from the certificate. The funeral director should file the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows an injury or other traumatic death, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                   |  |  |   |  |   |  |                 |  |  |  |
|--|--|--|-------------------|--|--|---|--|---|--|-----------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO. 84 13532 |  |  |   |  |   |  |                 |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 20. DATE OF DEATH |  |  | MONTH   |  | DAY   |  | YEAR            |  | 2b. HOUR                                     |  |
| WILLIAM H WELCH  |  |  | 05                |  |  | 05  |  | 84  |  | 2:40PM          |  |  |  |
| 3. SEX   |  | 4. RACE  |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS |  |  |  |
| m  |  | B  |                   | 3-27-1911  |  | 73  |  | YRS.  |  | MONTHS          |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                 |  |  |  |
| HARTFORD N.C.  |  | USA  |                   |  |  | BALTIMORE CITY  |  |   |  |                 |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                 |  |  |  |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL   |                   | FREIGHT HANDLER  |  |   |  |   |  |                 |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE  |  |                 |  |  |  |
| md   |  | BALTO  |                   | BALTO  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2208 E. LANVALE   |  |                 |  | (U3)   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT (WIFE) ADDRESS  |  |                 |  |  |  |
| WILLIAM  |  | MARY   |                   | Yes  |  | 218-01-6290   |  | PAULINE WELCH   |  | S/A             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | 18. IMMEDIATE CAUSE (a)  |                   | DUE TO, OR AS A CONSEQUENCE OF   |  | 18. (b)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | 18. (c)         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1629   |  | Cardiopulmonary Arrest   |                   | Lung Cancer  |  |   |  |   |  |                 |  | 10 mins.                                     |  |
|  |  |  |                   |  |  |   |  |   |  |                 |  | 2 Months                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.               |  |  |                   |  |  |   |  |   |  |                 |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |   |  |                 |  |  |  |
|  |  |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |                 |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |                   |  |  |   |  |   |  |                 |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION  |  |   |  |   |  |                 |  |  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                |  |  |                   | STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE           |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from  |  | april 30   |                   | 19   |  | 84  |  | to  |  | May 5           |  | 19   |  |
| saw the deceased alive on  |  | May 5  |                   | 19   |  | 84  |  | and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                 |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |                 |  |  |  |
| M. Jameson   |  | MD   |                   |  |  | 5/5/84  |  |   |  |                 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |                   |  |  |   |  |   |  |                 |  |  |  |
| M. JAMESON   |  | JOHNS HOPKINS HOSPITAL   |                   |  |  |   |  |   |  |                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |   |  |                 |  |  |  |
| BURIAL   |  | 5-10-84  |                   | CROWNVILLE VET.  |  | CROWNVILLE  |  | MD.   |  |                 |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |                 |  |  |  |
| BROWN - THOMPSON   |  | MAY 9 1984   |                   | Julia Davidson-Randall   |  |   |  |   |  |                 |  |  |  |

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO. **1 3 5 3 3**

FOR  
**1 - STATE**  
 REGISTRAR

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Catherine M. Wenchel</b> |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-13-84</b>                 |  | 2b. HOUR<br><b>5<sup>50</sup> A.M.</b>    |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-30-1913</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b> | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b> |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSP.</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERICAL</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INSURANCE</b>              |  |   |

|   |  |  |   |
|---|--|--|---|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1210 SHERIDAN AVE. 21239</b> |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b>                   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY K. CHENOWETH</b>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELEANOR BRAUER</b>               |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>          | 16b. SOCIAL SECURITY NO.<br><b>217-38-2818</b> | 17. INFORMANT ADDRESS<br><b>Mr. Lawrence Wenchel, Jr. - 1210 Sheridan Ave. 21239</b> |   |

|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  
**Asthma**

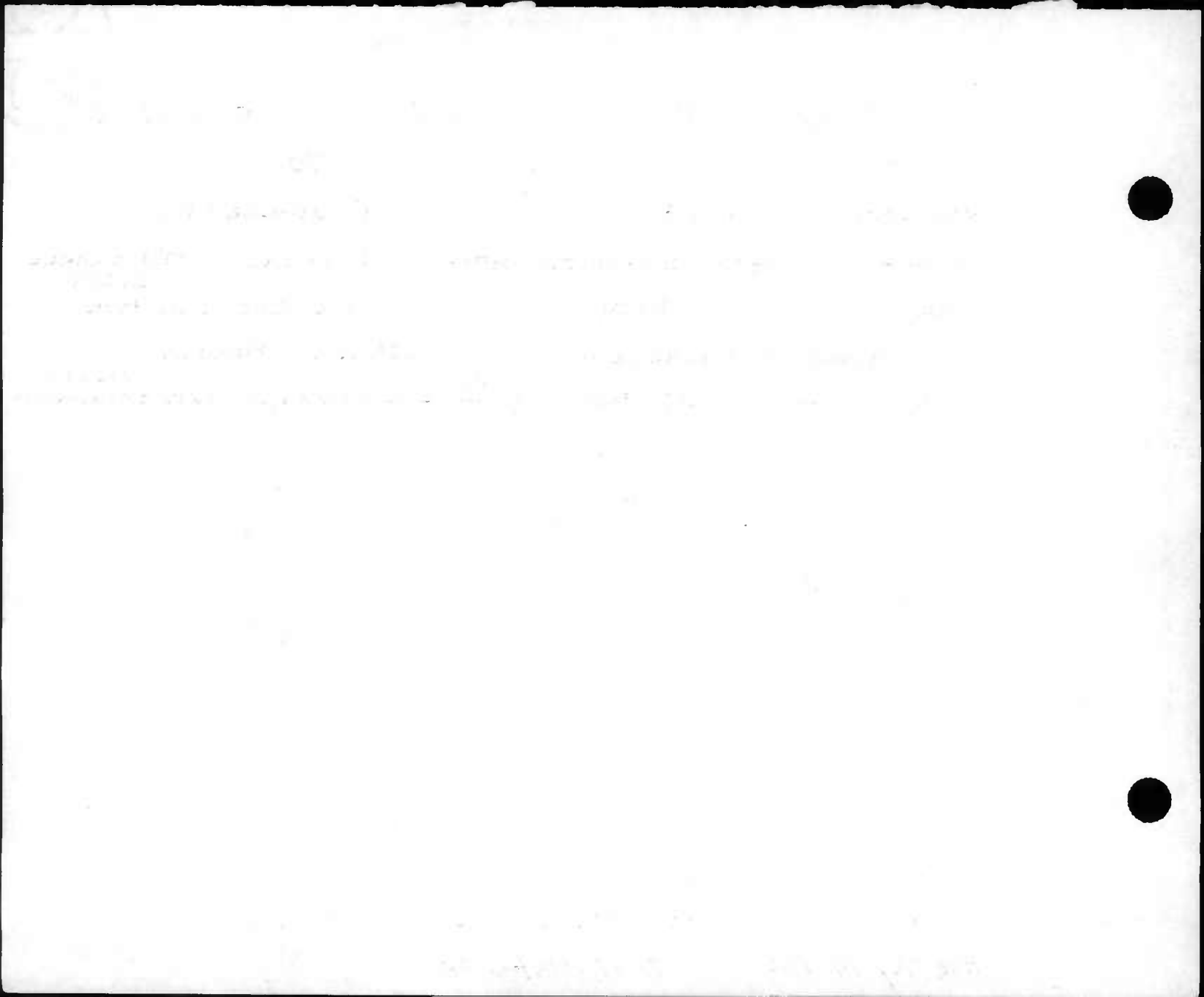
|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Martin D Valentine MD</b>  |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>5/14/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Martin D Valentine</b>  |  | 22e. ADDRESS   |  |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b> | 23b. DATE<br><b>5-16-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD Cem.</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARTLEY Miller</b>      |                             | ADDRESS<br><b>7527 HARford Rd</b>                           | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 14 1984</b>              |
|  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 13534

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |  | HOURS MIN.  |  |
| Hassie B West   |  | 05 26 84   |  | 12:24 PM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | 8. IF UNDER 1 YEAR  |  |
| Female  | black  | MONTH DAY YEAR   | 81 YRS.  | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |
| Georgia   | U.S.A.   |  | Baltimore City MD.   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Baltimore   | PROVIDENT HOSPITAL   |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |  |  | 3411 Kelox Road 21207   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |   |  |
| NO  |  | 215-10-3940  | Alberta West 3411 Kelox Road   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/48   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial ischemia vs Infarction  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
|   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |
|   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/23, 19 84 to 5/26, 19 84, that (I) (we) last saw the deceased alive on 5/26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two doctors did not view the body after death.) |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| Michael H. Owens, M.D.  |  |  |  | 5/26/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |
| Michael H. Owens, M.D.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (STATE)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| BURIAL  |  | 5/31/84  | Woodlawn Cemetery  | Baltimore Co., Md.  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  | 25a. DATE REC'D. BY REGISTRAR  |   |  |
| Wm C March F/H Inc. 1101 E North Avenue   |  |  | MAY 29 1984  |   |  |
|   |  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |
|   |  |  | Julia Davidson-Randall   |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 13535

1. FOR  
STATE  
REGISTRAR

REG. NO.

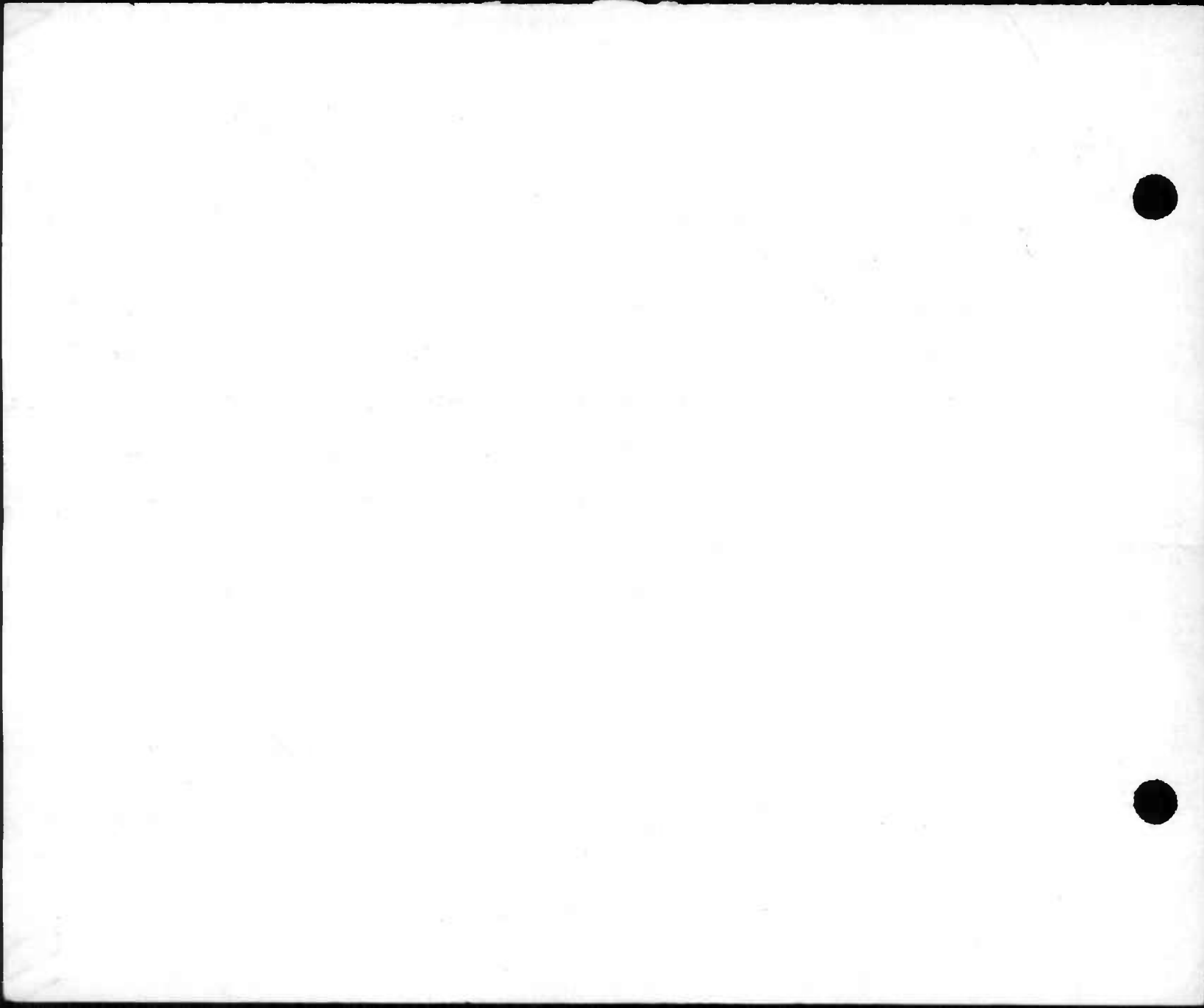
|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES EDWARD WEST</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>51 28 1 84</b>  |  | 2b. HOUR<br>M<br><b>M</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 21 27</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3604 Hillsdale Rd. 21207</b>              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James West</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hassie Miles</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-1126</b>  |   | 17. INFORMANT ADDRESS<br><b>Margarine H. West 3604 Hillsdale Rd.</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hrs.</b><br><b>YRS.</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>Severe Congestive Heart Failure and Pacemaker insertion 5/84 (5-11-84)</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/4</u> , 19 <u>84</u> , to <u>5/18</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>John F. Marra MD</u>  |  | DEGREE  |   | 22c. DATE SIGNED<br><u>5/28/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. MARRA MD</b>   |  | 22e. ADDRESS<br><b>5601 LOCK RAVEN BLVD 21239</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BURIAL)  |  | 23b. DATE<br><b>5/31/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>   |   |  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain the certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the hospital or with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate death certificate filed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 5 3 6  
REG. NO.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(LAST, FIRST, MIDDLE)<br><i>Pauline Westmoreland</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5-15-84</i>                           |   | 2b. HOUR<br><i>8:10 P.M.</i>                                   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6-21-22</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Burke, N.C.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>none</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| 13a. STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>-</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><i>2606 OAKLEY AVE 21215</i> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ernest Hardy</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Claudy Chambers</i>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>219-30-8173</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Ernesteen Vaughan 2606 Oakley Ave</i>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i><br><i>4413</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Rupture Aortic Aneurysm</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><i>5-11-84</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Leaking Aneurysm</i>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-11</i> , 19 <i>84</i> , to <i>5-15</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>5-15</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |   |   |  |
| 22b. SIGNATURE<br><i>G. Karpian</i>  |  | DEGREE<br><i>MD</i>  |   | 22c. DATE SIGNED<br><i>5/15/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>G. KARPAN MD</i>   |  | 22e. ADDRESS<br><i>Sinai Hospital Baltimore MD</i>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>5-19-84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Pk.</i>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore MD</i>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><i>Calvin B. Scruggs</i>   |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 17 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles H. ...</i>  |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

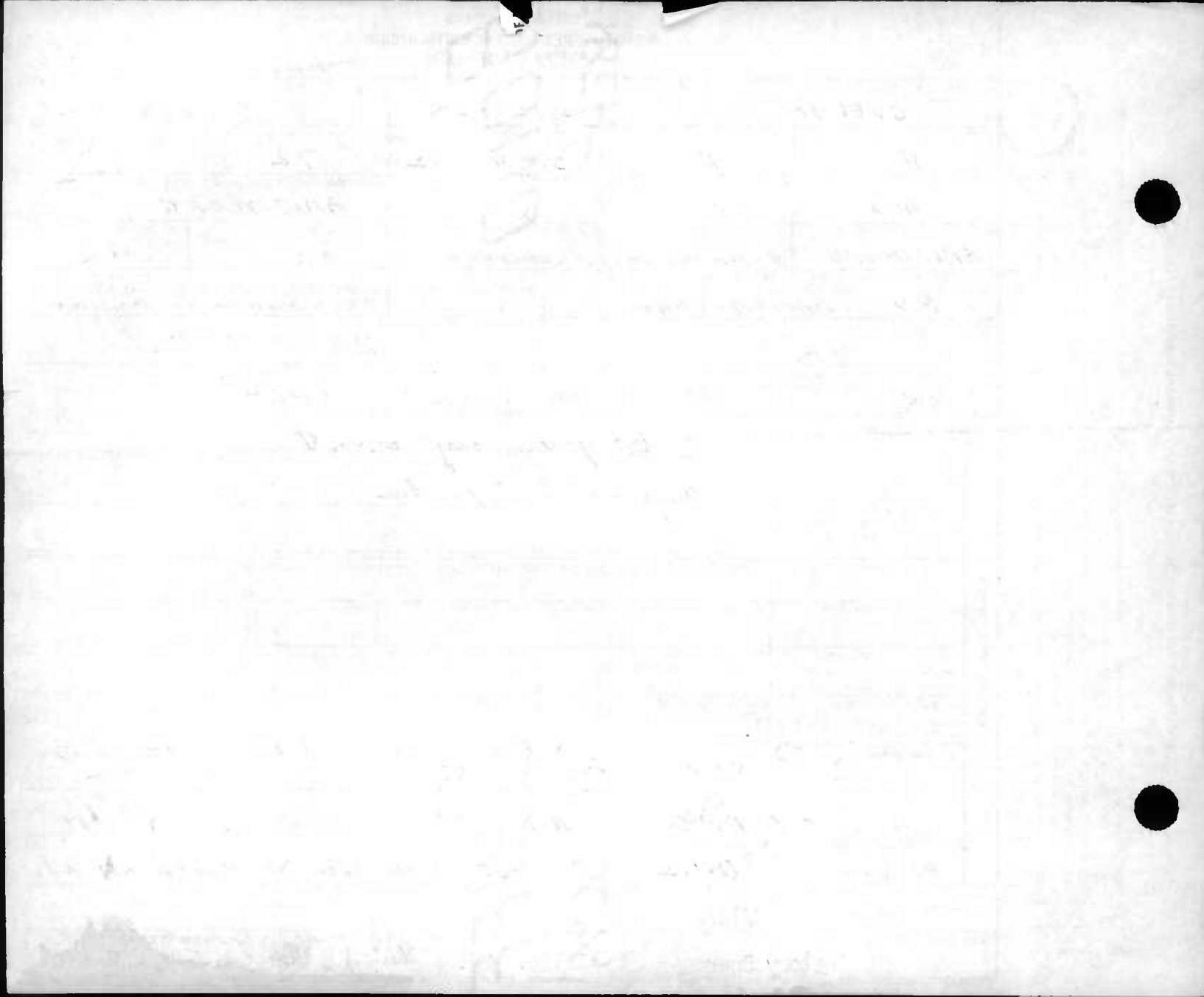
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |  |  |   |  |  |
|--|--|---|---|---|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | 8 REG. NO. 13537  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EVERYN WHITELEK  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 10 84   |  |  | 2b. HOUR<br>10:42 P.M.  |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>B  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 4 12   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>72                             |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 74 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.                  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSP. |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UK    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>UK   |  |  |
| 13a. STATE MD  |  |   |   |   | 13b. COUNTY BALTIMORE   |  | 13c. CITY OR TOWN BALTIMORE                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UK  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UK/GUSSIE HILL  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>UK  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>215-16-7940   |  | 17. INFORMANT ADDRESS<br>CHART 506H          |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>84</u> , to <u>5/10</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>5/10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE <u>Alfonso A. Ortiz</u>   |  |   |   |   | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>5/10/84   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALFONSO A. ORTIZ  |  |   |   |   | 22e. ADDRESS<br>3001 S. Hanover St. Baltimore Md.   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  |   | 23b. DATE<br>5/14/84  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE      |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board   |  |   |   |   | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 18 1984 |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 REG. NO. 1 3 5 3 8

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Amos WHITE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 9, 1984</b>                     |   | 2b. HOUR<br><b>11:47A<sub>M</sub></b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/25/25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>58</b>  |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Jarrett, Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13a. STATE<br><b>Maryland</b>   |   |  | 13b. COUNTY<br><b>Baltimore</b>                                   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Patrick White</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Phyllis White</b>         |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1100 Bolton Street 21201</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>237-30-8018</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Naomi E. White 1100 Bolton Street</b>                 |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Remote, left ventricular myocardial ischemic scar.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), stating the<br>underlying cause last.  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Chronic obstructive pulmonary disease</b>  |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 5</b> , 19 <b>84</b> , to <b>May 9</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 9</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Donald Human, M.D.</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>5/9/84</b>                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald Human, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/11/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leroy O. Dyett &amp; Son 4600 Liberty Heights</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>        |  |   |  |



1. The first thing I noticed when I stepped out of the plane was the cold. It was a sharp contrast to the warm, humid air of the tropics. I shivered as I walked down the ramp, my hands tucked into my pockets. The ground beneath my feet was hard and uneven, a mix of dirt and gravel. I looked up at the sky, where a few wispy clouds were scattered across a pale blue expanse. The sun was high, casting a bright, harsh light over everything. I felt a little disoriented, as if I had been transported to a different world. The silence was palpable, broken only by the distant hum of the plane's engines and the occasional rustle of leaves in the wind. I took a deep breath, trying to steady my nerves. This was it. The beginning of a new adventure. I knew that whatever lay ahead, I would face it with courage and determination. I was ready for whatever came my way.

2. As I walked further into the forest, the air grew thicker and more oppressive. The trees were tall and ancient, their branches reaching out like giant hands. The ground was covered in a thick carpet of moss and ferns, their colors a mix of vibrant greens and earthy browns. I could hear the soft drip of water from a nearby stream, a sound that seemed to echo through the dense canopy. The light filtered through the leaves in dappled patterns, creating a magical atmosphere. I felt a sense of wonder and awe, as if I had stumbled upon a hidden world. The silence was no longer empty; it was filled with the sounds of nature, from the chirping of birds to the rustling of leaves. I knew that this was a special place, a place where time seemed to stand still. I took a moment to pause, looking up at the towering trees and feeling a small part of myself merge with the forest. I was here, in the heart of the wilderness, and I was exactly where I needed to be.

3. The journey was not without its challenges. There were moments of doubt and fear, moments when I questioned my ability to survive in such a remote and dangerous place. But I pushed through, driven by a deep desire to explore and discover. I learned to read the signs of nature, to listen to the whispers of the wind and the rustle of leaves. I found strength in the solitude, in the knowledge that I was alone but not isolated. I was part of something greater, a part of a vast and beautiful world that was waiting for me to uncover its secrets. I knew that this journey would change me, that it would shape me into a person I had never been before. I was ready for whatever came my way.

4. The end of the journey was as much a revelation as the beginning. I had reached a place where I had never been before, a place where I had found myself. I had discovered the beauty and power of the natural world, a world that was so much more than I had ever imagined. I had learned the value of patience and persistence, of the importance of staying true to oneself. I had found a sense of purpose and meaning in the most unexpected of places. I knew that this journey would stay with me for the rest of my life, a reminder of the incredible things I was capable of. I was grateful for every moment, for every challenge I had faced. I was grateful for the journey, for the discovery of myself and the world around me. I was ready for whatever came my way.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 5 3 9  
REG. NO.

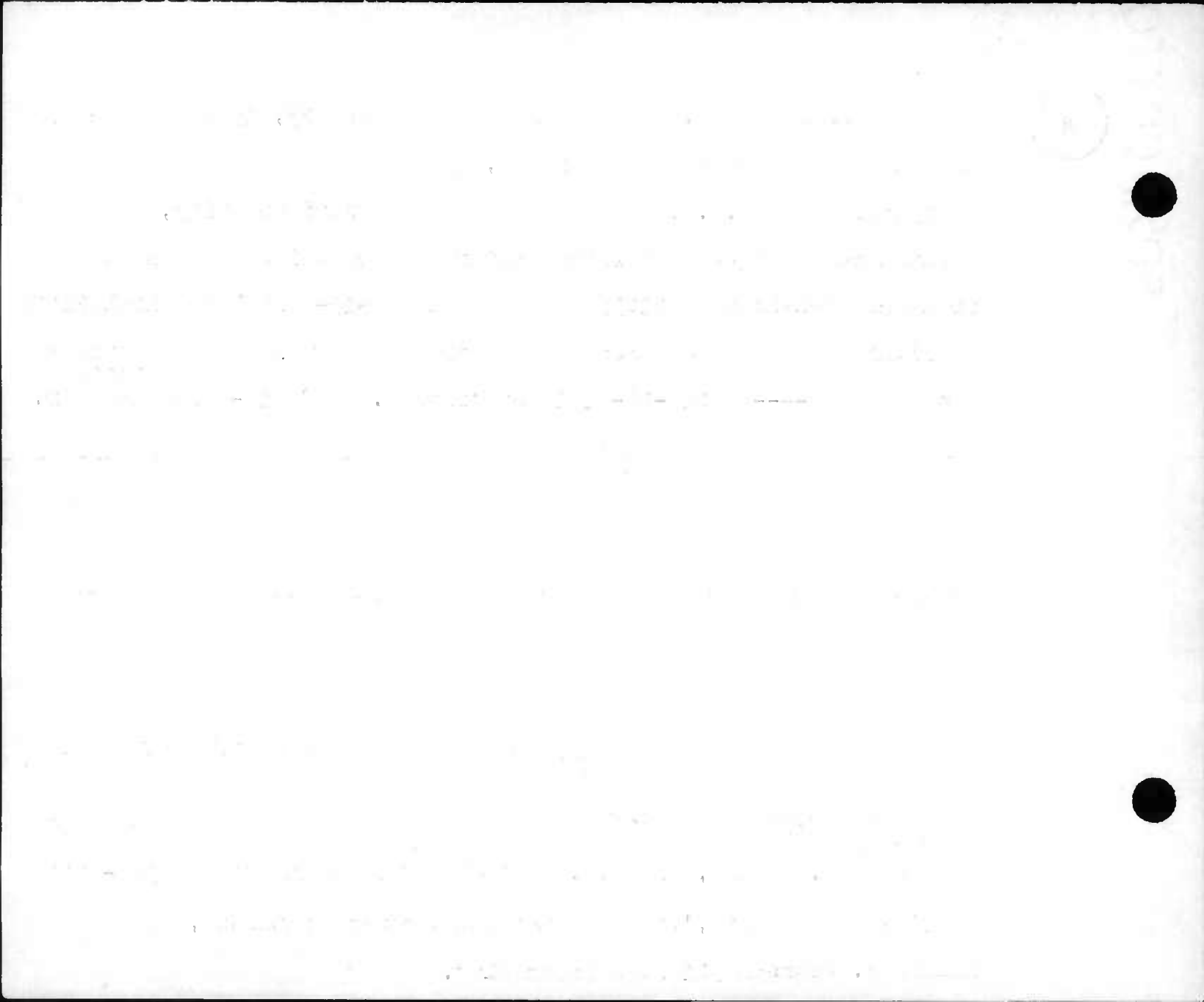
1. FOR  
STATE  
REGISTRAR

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELLEN C. WHITE</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 25, 1984</b>                           |   | 2b. HOUR<br><b>7:00PM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 4, 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br><b>Maryland Baltimore</b>   |   |   | 13c. CITY OR TOWN<br><b>21239</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Buchanan</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Theresa Murray</b>          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-34-9141</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Catherine W. Codd 21239 6915-B Lachlan Cir.</b>                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>5990</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Urinary infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic</b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>organic dementia Alzheimer type. Emphysema - Anemia</b>  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Jan 1</b> 19 <b>83</b> to <b>May 25</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 23</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                      |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Joseph W. Zebley, III</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4-26-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph W. Zebley, III M.D.</b>  |   | 22e. ADDRESS<br><b>3809 Green Mount Avenue 366-6222</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>May 29, '84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>   |   | ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1984</b>   |  |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |   |   |  |
|--|--|--|--|---|--|--|--|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 84 13540  |  |   |  |  |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ARTHUR WHITFIELD  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5-16-84                                    |  |  | 2b. HOUR<br>2:00 A M  |   |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 14 53   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>31 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MONTEBELLO CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |   |   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>938 Abbott Court 21202   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sollie Whitfield   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Armstrong       |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |   |   | 16b. SOCIAL SECURITY NO.<br>214-58-5158 |  |
| 17. INFORMANT<br>Annie Whitfield   |  |  | ADDRESS<br>938 Abbott Court  |   |  |  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br><u>4860</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RECURRENT ATELECTASIS &amp; PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>C1 QUADRIPLÉGIA</u>  |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>5 min.   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 19 <u>82</u> , to <u>5/16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br><u>E. B. Hayward</u>   |  |  |  |   | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>5/16/84   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. B. Hayward MD  |  |  |  |   | 22e. ADDRESS   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>5/22/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.                        |  |  | 23d. LOCATION<br>Baltimore, COUNTY MD.                          |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 17 1984                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendall   |   |   |   |  |



ATM

WHITFIELD

2-16-84

NEED

WALL

CENTER

WATERLOO

BATHING

RESEARCH ATTEMPT: 1. 1/1/1/1

C. Anderson

X

1/1/1/1

2/1/1/1

C. Anderson

T. L. Anderson

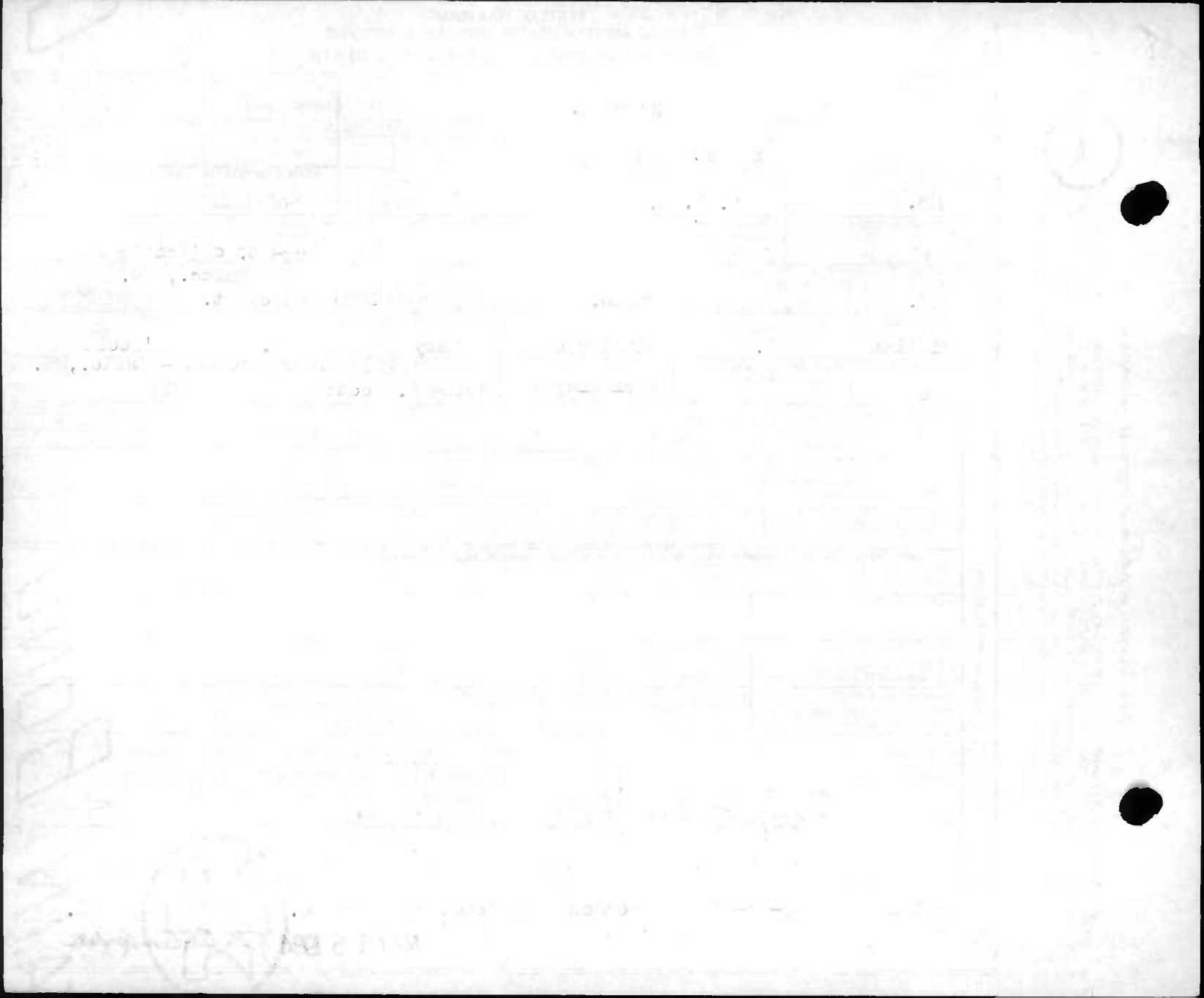


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |  |  |   |  |   |  | REG. NO. 3 5 4 1   |  |                           |  |
|--|--|--------------|--|--|--|---|--|---|--|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FRANCES Audrey L. WIEGAND   |  |              |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>5 -9-84 19 |  | 2b. HOUR<br>M<br>11:15 am |  |
| 3. SEX<br>F  |  | 4. RACE<br>W |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 10 14  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>69 YRS.        |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5-9-84 19                                  |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                               |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2011 Ramsey Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk-State of Maryland  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                           |  |
| 13a. STATE<br>Md.  |  |              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS Balto., Md.<br>2011 Ramsey St. #21223                                |  |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Dunnington  |  |              |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary F. O'Toole              |  |   |  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |              |  | 16b. SOCIAL SECURITY NO.<br>212-09-9161  |  | 17. INFORMANT 2011 Ramsey Street - Balto., Md.<br>Martha L. Scott #21223      |  |   |  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____   |  |              |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |              |  |  |  |   |  |   |  |  |  |                           |  |
| 19a. DATE OF OPERATION   |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |              |  |  |  |   |  |   |  |  |  |                           |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |  |              |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>5-9-84   |  |  |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |              |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |              |  | 23b. DATE<br>5-14-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Schwab  |  |              |  | ADDRESS<br>3512 Frederick Ave. # 2124  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 18 1984                                  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |  |                           |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413542

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |                            |  |  |
|---|--|---|---|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL WIGGINS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 15 84</b> |  | 2b. HOUR<br><b>11 A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-17-08</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Circle Hospice</b> |   | 12a. BALTIMORE CITY OR COUNTY OF DEATH<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Wiggins</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clacy Robinson</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |                            | 16b. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Lillie May Key</b>  |  | 18. STREET ADDRESS / ZIP CODE<br><b>204 N. Fremont Ave (01)</b>   |   | 19. DATE OF OPERATION  |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 21a. DATE OF OPERATION  |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                            | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 22b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10:29:77 5-15-84</b>  |   | 22c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                            | 22d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |  |
| 23a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 23b. DATE<br><b>5-19-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |  |
| 24. I certify that (I) (this hospital) attended the deceased from <b>10-29-77</b> , 19 <b>84</b> , to <b>5-15</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John T. ...</b>   |                            | 25c. DATE SIGNED<br><b>5-16-84</b>   |  |
| 26a. SIGNATURE<br><b>E. Ellsworth Cook</b>  |  | 26b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Ellsworth Cook MD</b>  |   | 26c. ADDRESS<br><b>2431 Maryland Ave. Baltimore MD</b>   |                            | 26d. DATE SIGNED<br><b>5-16-84</b>   |  |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 27b. DATE<br><b>5-19-84</b>   |   | 27c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |                            | 27d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |  |
| 28. FUNERAL DIRECTOR<br>NAME<br><b>Chas.A.Rice FSPA</b>   |  | 28b. ADDRESS<br><b>1300 Eutaw Pl.</b>   |   | 28c. DATE REC'D. BY REGISTRAR  |                            | 28d. REGISTRAR'S SIGNATURE<br><b>MAY 18 1984</b>   |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**3429**

DUE TO, OR AS A CONSEQUENCE OF

(b)

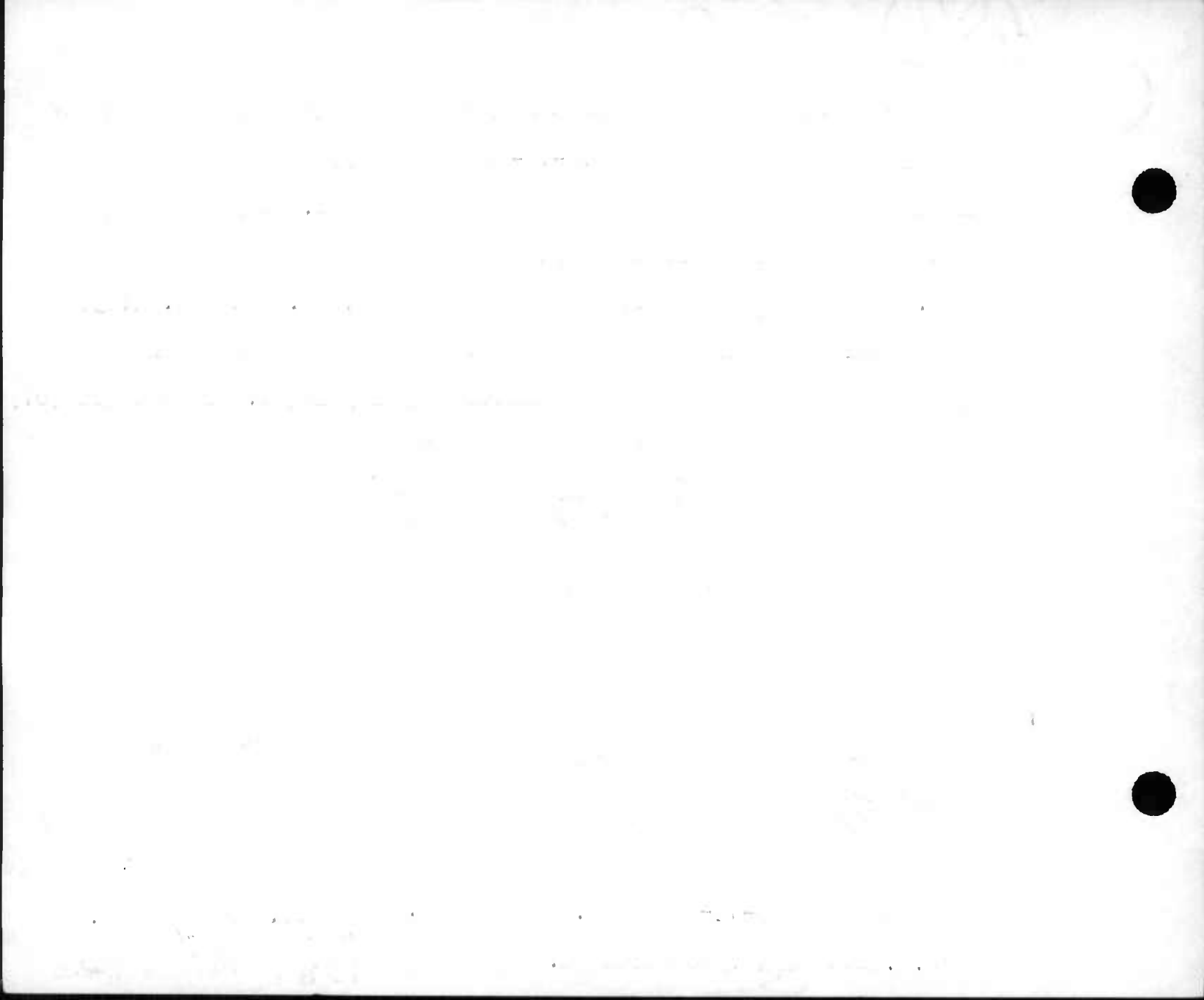
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**10 years****10 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**stress incontinence****12 years**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 5 4 3  
REG. NO.

|  |  |  |   |   |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|---|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William J. Wiggins</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 8 1984</b>                          |   |  | 2b. HOUR<br><b>M</b>   |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 27 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                    |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |  |   |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Saint Agnes Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Mechanic</b>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>  |  |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2029 Northeast Ave. Baltimore, Maryland 21227</b>                                     |  |  |   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Wiggins</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Betty Wiggins</b>   |  |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b> |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-2985A</b> |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Dorothy W. Wiggins Baltimore, Md. 21227</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Pulmonary Emboli</b><br><b>4511</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Deep Vein Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Respiratory Insufficiency</b> |  |  |   |   |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>History of Diabetes Mellitus</b>   |  |  |   |   |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>10-28-83</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Deep Vein Thrombosis</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>               |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-28-83</b> , 19 <b>83</b> , to <b>2-8</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Aldo Paz-Guevara</b>  |  |  | DEGREE <b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>5-9-84</b>  |  |  |   |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aldo Paz-Guevara</b>   |  |  | 22e. ADDRESS<br><b>3350 Wilkens Ave. 21229</b>                                  |   |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  |  | 23b. DATE<br><b>5/12/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>           |  |  |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons Funeral Home Inc.</b><br>ADDRESS<br><b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                        |  |  |  |   |  |  |  |  |  |  |  |

1. Name: William J. Higgins  
 2. Address: 1000 North Ave. Baltimore, Md. 21201  
 3. Date: 10-1-1968  
 4. Reason: ...  
 5. ...  
 6. ...  
 7. ...  
 8. ...  
 9. ...  
 10. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413544  
REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Amelia B. Wilhelm  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 15, 1984 |   |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 10, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |   |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7311 Knollwood Road 21204  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Beck  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Deurschinger  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>212 74 3562  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Mary D. Schroeder 7311 Knollwood Rd.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for last; (b) and (c) are optional)<br>PART 1. DEATH WAS CAUSED BY<br>4409 IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |  |  |
| <u>Arthritis</u>  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1984</u> to <u>May 15, 1984</u> that (I) (we) last saw the deceased alive on <u>April 12, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (we) and not view the body after death.  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>W. G. Helfrich</u>   |  |  |   | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>May 16, 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. G. Helfrich, MD.  |  |  |   | 22e. ADDRESS<br>5006 Roland Ave. Baltimore, Md.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/17/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME, INC.   |  |  |   | ADDRESS<br>6500 York Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |

BP.

1941, 11/11

1941, 11/11

1941, 11/11

1941, 11/11

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1941, 11/11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 5 4 5

REG. NO.

FOR  
1 - STATE  
REGISTRAR

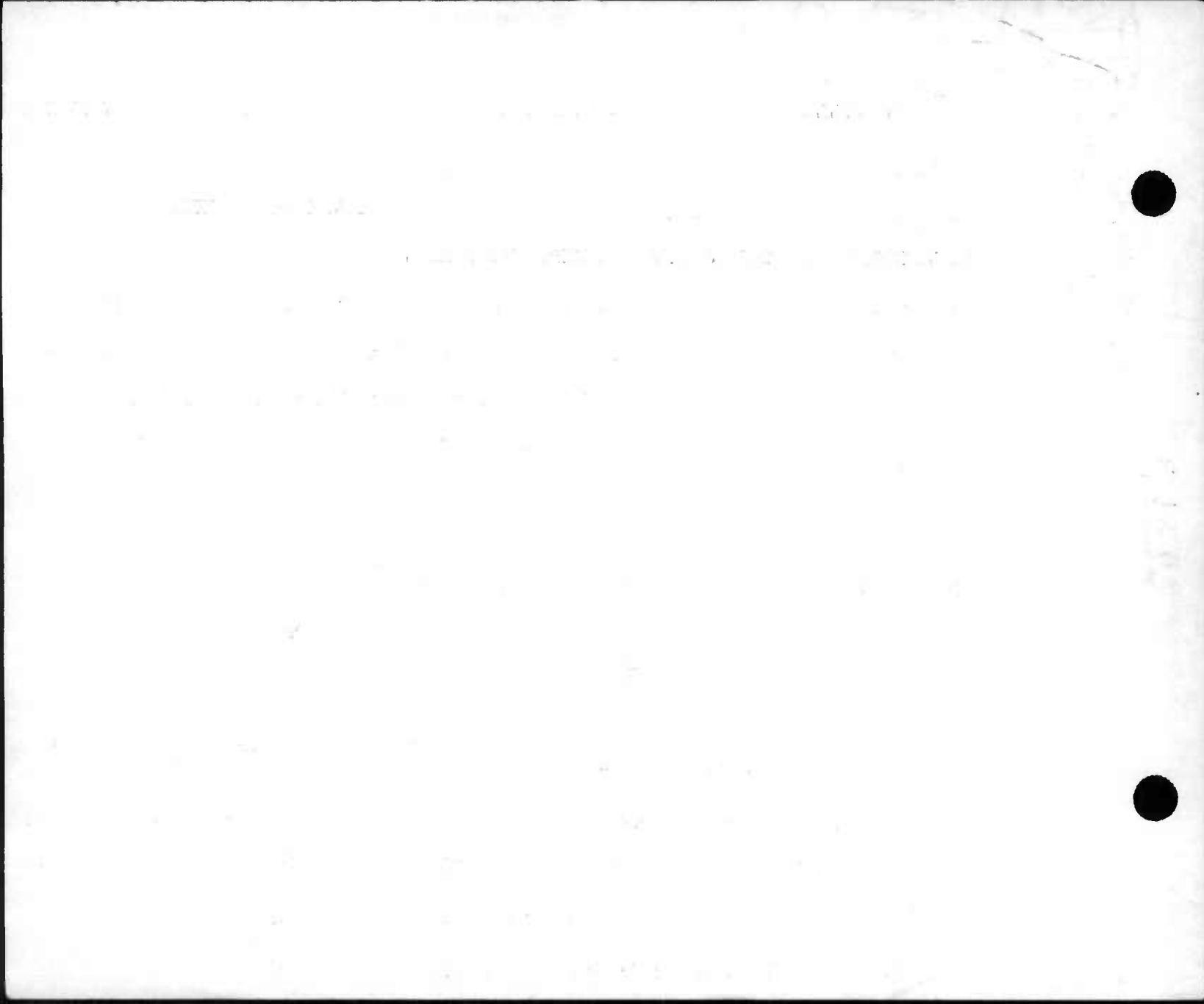
|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LUCILLE WILKERSON CREWS</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>05 21 84</b>                       |  | 2b. HOUR<br><b>7:15PM</b>   |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rosco Peterson</b>   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cornellia Peterson</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) <b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>229-54-2636</b>                            | 17 INFORMANT ADDRESS<br><b>Rose Fincher 1324 N. Bond Street</b>                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4349 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRAINSTEM INFARCT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 days</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>0</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Hepatic Failure; Acute and Chronic Renal Failure</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (If (this hospital) attended the deceased from <b>13 MAY 19 84</b> to <b>21 MAY 19 84</b> , that (I) (we) last<br>saw the deceased alive on <b>21 May 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Raymond W. Wilson, M.D.</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>21 May 1984</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/26/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cem.</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lansdowne, Md.</b>   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>                          |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal unit must be notified at once.



5

per phone F. H. mtb 5/14/84

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

84 13546  
REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANGELA M. WILLIAMS</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 3, 1984</b>  |  | 2b. HOUR<br><b>11:00</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 15 65</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>19 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Penna.</b>   |  | 13b. COUNTY<br><input checked="" type="checkbox"/>   |  | 13c. CITY OR TOWN<br><b>Coatesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CLARENCE WILLIAMS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JHERESA Winfield</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>CLARENCE WILLIAMS</b>   |  | ADDRESS<br><b>745 Valley Rd.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>5150<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumothorax</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pulmonary fibrosis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 HRS</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Reduction E.B.P. 2° Lymphoblastic lymphoma Pneumocystis C.</b>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPTIC<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/4/84</b> to <b>5/3/84</b> , that (I) (we) lost saw the deceased alive on <b>5/4/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James Kahn</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br><b>5/3/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES KAHN</b>  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP</b>  |  | 22f. BALTO. MD. 21205  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-8-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westchester Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westchester Co. NY</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Dailey Funeral Home</b>  |  | ADDRESS<br><b>1749 Calhoun</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 8 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

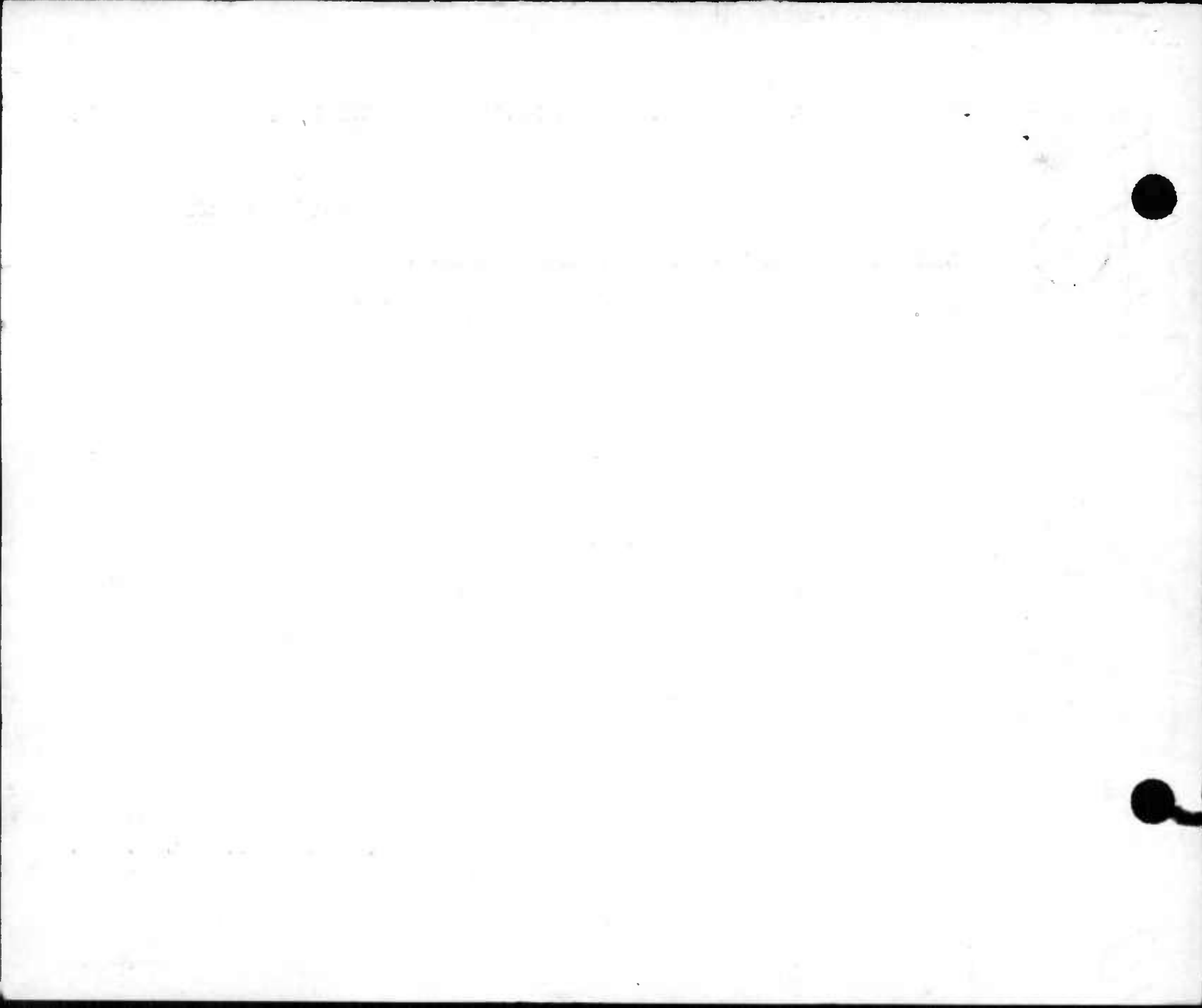
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial permit. Then please return to the Department of Health and Mental Hygiene, page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other violent event, the medical examiner must be notified.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413547  
REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
|   |  | ANNIE MAUDE WILLIAMS  |  | MAY 28 1984   |  | 4:15A M   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE  |  | BLACK   |  | APR. 12, 1919   |  | 65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| NORTH CAROLINA  |  | US of A   |  |   |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE   |  | 3805 HAYWOOD AVENUE   |  | RETIRED   |  | HOME MAKER  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND  |  |   |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS / ZIP CODE  |  |   |  |
| WILLIE MURPHY   |  | WILLIE ANN JONES  |  | 3805 HAYWOOD AVENUE   |  | 21215   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |
| NO  |  | 243 26 3402   |  | MR. JAMES WILLIAMS  |  | 3805 HAYWOOD AVENUE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u><br><u>4280</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cardiac arrhythmia (vent tach)??</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>end stage CHF.</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | ASCUS / Bilateral cerebral aneurysm / WIDM / IHD P / -  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <u>April</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |  | 19 <u>81</u> to <u>May</u> 19 <u>84</u>   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Jose R. Alvarez</u>  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>5-29-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jose R. Alvarez M.D.   |  | 22e. ADDRESS<br>Sinai Hospital.   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| BURIAL  |  | 6/3/84  |  | SNOW HILL CEMETERY  |  | ROCK FISH (ROBINSON) N.C.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| LEWIS T. GWYNN  |  | 4517 PARK HEIGHTS AVENUE  |  | MAY 31 1984   |  |   |  |

BP

MAY 28 1954 4:15A

65

MAY 15, 1954

1954

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ST. LOUIS, MO.

X

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3805 HAYWOOD AVENUE  
ST. LOUIS, MO.

3805 HAYWOOD AVENUE

3805 HAYWOOD AVENUE

3805 HAYWOOD AVENUE

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3805 HAYWOOD AVENUE

3805 HAYWOOD AVENUE

JOHN

AND

WILLIAM

MURPHY

WILLIAM

3805 HAYWOOD AVENUE ST. LOUIS, MO. 63115

NO

ROBERTSON (ROBERTSON) R.C.

ST. LOUIS, MO.

6/3/54

BURIAL

ST. LOUIS, MO. 63115

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH84 13548  
REG. NO.

|  |  |  |  |   |                            |  |  |
|--|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIS, LOUIS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 7 84</b> |   | 2b. HOUR<br><b>6:00 AM</b> |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 8 25</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>58</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Willis, Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alma Walker</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4753 Park Heights Avenue 21215</b>   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>375-28-3272</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Joseph Walker 4753 Park Heights Avenue</b>   |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBROVASCULAR ACCIDENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/7/84</b> , 19____, to <b>5/7/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>5/7/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>5/7/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>UDOTT OSWALD, MD</b>   |  | 22e. ADDRESS<br><b>2600 LIBERTY TRAIL, BALT</b>  |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/12/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 9 1984</b>  |                            |  |  |
|  |  |  |  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                            |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NAME: T. S. C.

Address:

City: S. M.



DATE: APR. 21 1953

To: Mr. J. H. [illegible]

From: Mr. T. S. C.

Subject: [illegible]

RE: [illegible]

1953-7-10-11, T. S. C. [illegible]

1953-7-10-11, T. S. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | 84 13549   |                                   |
|--|---|---|---|--|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| JAMES WILSON   |   | 5 22 84   |   | 757P   |                                   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   |
| Male   | White   | 5 12 08   | 76  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| North Carolina   | USA   |   | BALTIMORE CITY MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore City   | Baltimore City Hospital                                 |   | Warehouseman  |  | Railway Express                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |                                   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                   |
| Maryland   | Baltimore   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1809 Summit Ave. 21237   |                                   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |
| Lucius Wilson  |   | Mary Elizabeth Smiley   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |
|  |   | 216-10-9354   |   | Erma T. Wilson 1809 Summit Ave. Balto. Md.                                     |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:   |   |   |   |  |                                   |
| IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>   |   |   |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>  |   |   |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |   |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |   |   |   |  |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   |
|  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|  |   | HOUR A.M. MONTH DAY YEAR  |   |  |                                   |
|  |   | P.M. 19   |   |  |                                   |
| 21d. INJURY OCCURRED   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION  |                                   |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   |   |   | CITY OR TOWN COUNTY STATE  |                                   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5-20</u> 19 <u>84</u> to <u>5-22</u> 19 <u>84</u> , that (1) (we) lost saw the deceased <u>live on</u> <u>5-22</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |   |   |   |  |                                   |
| 22b. SIGNATURE   |   | DEGREE  |   | 22c. DATE SIGNED   |                                   |
| Daniel M. Perlman  |   | MD  |   | 5-22-84  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |   |  |                                   |
| DANIEL M. PERLMAN  |   | Baltimore City Hospitals  |   | Balt. 21224  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Burial   |   | 5-26-84   |   | Gardens of Faith   |                                   |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
| LASSAHN F. H.  |   | MAY 28 1984   |   | John Davidson-Randall  |                                   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

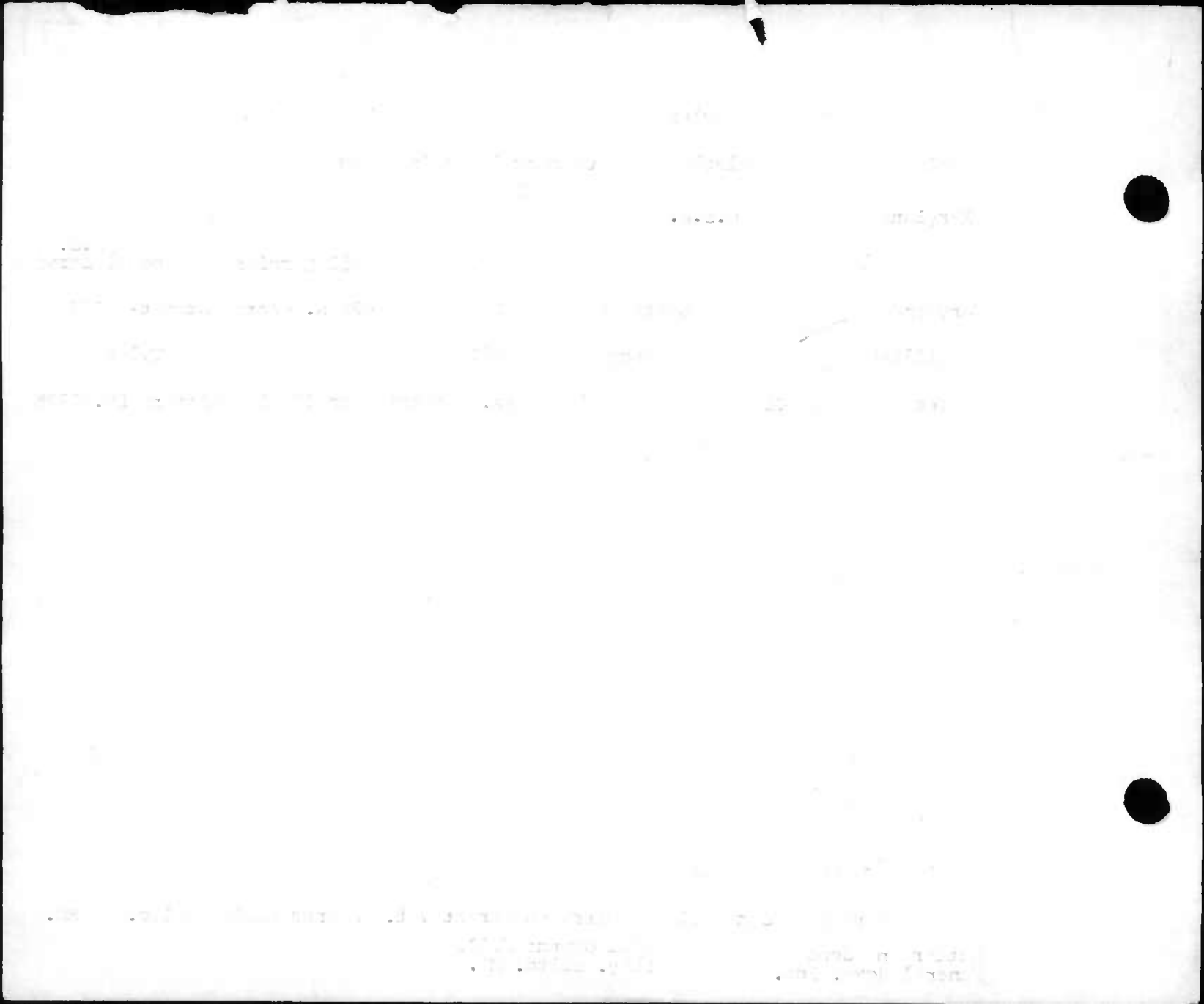
84 13550  
REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>NORMAN Tyler WILSON  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 29, 1984  |  | 2b. HOUR<br>1:20p M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 13 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER BALTO MD  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mail Carrier  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Postal Service  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>824 N. Monroe Street-21217       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Wilson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Tyler  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II   |  | 16b. SOCIAL SECURITY NO.<br>218 05 1416   |  | 17. INFORMANT ADDRESS<br>Mrs. Eleanor Randall 164 Winters La.21228 |  |
| MEDICAL CERTIFICATION   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY Arrest</u><br><u>1850</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Terminal metastatic Prostate Cancer.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) _____ |  |   |  |   |  |  |  |
|   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |   |  |  |  |
|   |  | 19a. DATE OF OPERATION   |  |   |  |   |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <u>May 8,</u> 19 <u>84</u> to <u>May 29,</u> 19 <u>84</u> that (x) (we) lost saw the deceased alive on <u>May 29</u> 19 <u>84</u> and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) and (x) (we) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>R. Phillips</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><u>5/30/84</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. Phillips M.D.   |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto Md 21218   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>June 5, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills Balto. Md.                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>Nutter and Sons<br>Funeral Home, Inc.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>E. J. [Signature]</u>  |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death certificate should be filed at the Baltimore Medical Examiner's Office.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8413551  
REG. NO.

|   |  |                     |  |   |   |   |   |   |  |   |  |  |
|---|--|---------------------|--|---|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Reedy Wilson</b>   |  |                     | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>9</b> YEAR <b>84</b>  |   |   | 2b. HOUR<br><b>1250A</b>  |   |   |  |   |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b> |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>22</b> YEAR <b>22</b> |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | 8. IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b> |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1215 Argyle Avenue</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                  |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |                     | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                           |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1215 Argyle Avenue 21216</b>  |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>   |  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |   |   | 16b. SOCIAL SECURITY NO.<br><b>722-16-0765</b>                     |   | 17. INFORMANT<br>ADDRESS<br><b>ANNIE WILSON 1215 Argyle Ave.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest etiology unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |                     |  |   |   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                     |  |   |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/9</b> 19 <b>84</b> to <b>5/9</b> 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>5/9</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                     |  |   |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Robert Fuld</b>  |  |                     | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   |   | 22c. DATE SIGNED<br><b>5/9/84</b>                                  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Fuld</b>   |  |                     | 22e. ADDRESS<br><b>University Hospital</b>   |   |   |   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE) <b>BURIAL</b>  |  |                     | 23b. DATE<br><b>5/14/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b> |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills,</b> COUNTY <b></b> STATE <b>Ma.</b>  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  |                     |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julian Davidson</b>  |  |   |  |  |

BP

11/2/24

RECEIVED  
MAY 11 1924  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

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1. The first of these is the fact that the  
the second is the fact that the  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |   |
|--|--|--|--|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 8 4 1 3 5 5 2<br>REG. NO.   |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William R. Wilt   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 9 84  |   |  | 2b. HOUR<br>2352 PM  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 7 33  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3443 Roland Avenue 21211 |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Route Salesman |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Greenspring Dairy   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY -- 13c. CITY OR TOWN Baltimore  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>3443 Roland Avenue 21211                |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Hillary Wilt  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillian Ayers                                     |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>Korean 213-30-9180   |  | 17. INFORMANT ADDRESS<br>Mrs. Marie Wilt 3443 Roland Ave. 21211   |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic Small Cell Lung Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 months   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>83</u> , to <u>death</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><u>David E. Weissman</u>   |  |  |  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>5/10/84                                    |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David E. Weissman   |  |  |  |   | 22f. ADDRESS<br>600 W. Wolfe St. Baltimore, MD 21205  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5/12/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Memorial Gdns   |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Sykesville Maryland |  |   |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>A. Alan Seitz, Jr. 3818 Roland Ave. 21211   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAY 14 1984 <u>Julian T. ...</u>    |   |  |  |   |

(3)

1. The first part of the report is a general description of the project and its objectives. It is followed by a detailed description of the methodology used in the study. The results of the study are then presented in a series of tables and figures. The final part of the report is a conclusion and a list of references.

2. The second part of the report is a detailed description of the methodology used in the study. It includes a description of the data collection methods, the statistical methods used, and the software used for data analysis.

3. The third part of the report is a series of tables and figures that present the results of the study. The tables show the mean values and standard deviations for each variable. The figures show the distribution of the data for each variable.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the findings of the study and discusses their implications. The references list the sources of information used in the study.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |   |  |
|---|--|--|--|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MATTIE MIDDLE MAE LAST WINGATE   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH 5 DAY 3 YEAR 84                     |   | 2b. HOUR<br>6:40 A.M.                               |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH 2 DAY 12 YEAR 29  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |   |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>5214 Ready Avenue 21212   |  |
| 14. FATHER'S NAME<br>FIRST Charles MIDDLE LAST Green  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Carey MIDDLE LAST Montgomery |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>250-38-5528   |  | 17. INFORMANT ADDRESS<br>Larry Green 5214 Ready Avenue  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>3400<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Multiple sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>None</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Recent D/C from JHH - ulcers, decubitus</u>  |  |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/3</u> , 19 <u>84</u> , to <u>5/3</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><u>David S. Dunn</u> MD   |  |  |  |   | DEGREE<br>MD   |   |   | 22c. DATE SIGNED<br>5.3.84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID S. DUNN  |  |  |  |   | 22e. ADDRESS<br>201 E. University Pkwy.                        |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>5/9/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk   |  | 23d. LOCATION<br>Arbutus, COUNTY Md.  |   |   |  |
| 24. FUNERAL DIRECTOR<br>Wm C March F/H Inc. 1101 E North Avenue   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 4 1984                    |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified on page 4.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH84 13554  
REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Loretta Ruth Winkler</b>   |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 31, 1984</b>                                   |  | 7b. HOUR<br><b>8:02</b> AM  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 27, 1917</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Baltimore, Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City, MD.</b>                          |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2916 E. Pratt Street</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>----</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>2916 E. Pratt St. - 21224.</b>  |  |   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence --- Jacob</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia ---- Schmick</b>                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>----</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-48-2884</b>  | 17. INFORMANT <b>Baltimore, Md. 21224</b><br><b>Mr. William A. Winkler-2916 E. Pratt St.</b> |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Lung Cancer with Metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>2 1/2 months</b><br>(c) <b>2 1/2 months</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |
| 9a. DATE OF OPERATION<br><b>---</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. --- 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>---</b> |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b>  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>---</b>                                     |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> , 19 <b>84</b> , to <b>5/31</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.                                       |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Bayani B. Churruarin</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/31/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BAYANI B. ELMA, M.D.</b>  |  | 22e. ADDRESS<br><b>3023 Eastern Avenue Balt 21224</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>6/4/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory - Baltimore, Maryland</b>     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |
| 24. FUNERAL DIRECTOR <b>John A. Moran, Inc. Funeral Home</b><br>NAME ADDRESS<br><b>3000 E. Baltimore St., Baltimore, Md. 21224</b>  |  |   |  |  |   |

DATE REC'D. BY REGISTRAR 25/ REGISTRAR'S SIGNATURE  
**JUN 4 1984**

Location: Fair Winkler  
 MONDAY 1934 802 A

|                |                      |               |                           |
|----------------|----------------------|---------------|---------------------------|
| Female         | White                | July 27, 1917 | 68                        |
| Baltimore, Md. | W. A. W.             | x             | Baltimore, City           |
| Baltimore      | 2916 E. Pratt Street |               | Houseswife                |
| Id.            | Baltimore            | x             | 2916 E. Pratt St. - 2152A |
| Lawrence       | Jacob                | Anna          | Id.                       |
| 215-48-2884    | 215-48-2884          | 215-48-2884   | 215-48-2884               |
| 215-48-2884    | 215-48-2884          | 215-48-2884   | 215-48-2884               |

2000 S. Baltimore St., Baltimore, Md. 2122A  
 John A. Brown, Inc. Funeral Home  
 Christian Church, 215 E. Lexington - Baltimore, Maryland

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

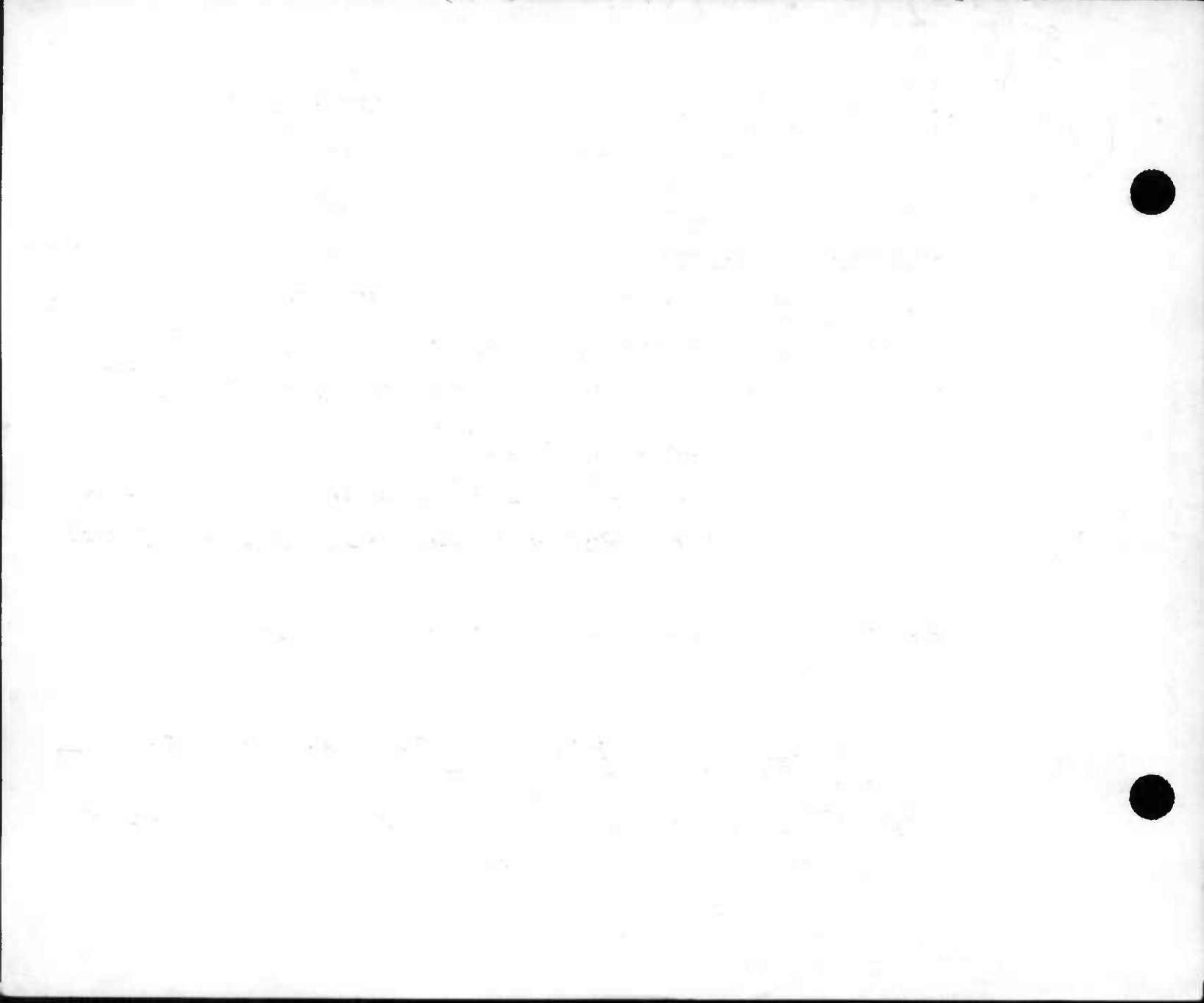
8 4 1 3 5 5 5  
REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANN A. WINSLOW</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 19 1984</b>   |  | 2b. HOUR<br><b>12:20 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 16 1948</b>                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>36</b>                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b>                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3503 JUNEWAY 21213</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERVIN S. PORTERA SR.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ADELE C. BURY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SOC. SECURITY</b>                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-52-1249</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>EDWINA BONOMO (SISTER) 4009 BAKER LANE 21236</b>      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>RHEUMATIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>STATUS POST AORTIC VALVE REPLACEMENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>3989</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 YEAR</b><br><b>3 MOS</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>2/24/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RHEUMATIC HEART DISEASE</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 28</b> , 19 <b>82</b> , to <b>MAY 19</b> , 19 <b>84</b> , that (I) <del>lost</del> saw the deceased alive on <b>APRIL 17</b> , 19 <b>84</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did not</b> view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Ernest S. Lewis, MD</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/24/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. KENNETH LEWIS</b>  |  | 22e. ADDRESS<br><b>SUITE 214 FRANKLIN SQ. MED. BLDG.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/22/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |  | 24. FUNERAL HOME<br>NAME ADDRESS<br><b>SCHMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213</b>   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Hendall</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours in the office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death must be notified to the



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>GERTRUDE</b>   |  | FIRST <b>GERTRUDE</b>   |  | LAST <b>WINSTON</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 5 7 84</b>                                |  | 2b. HOUR<br><b>1:45 AM</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>DEC 27 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>WEST VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b> Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM BRYANT</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>QUEEN</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br><b>214-22-4855</b>   |  | 17. INFORMANT <b>HERBERT L. WINSTON</b> 45417<br><b>3341 W. SECOND ST. DAYTON, OHIO</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> 19 <b>84</b> to <b>5-7</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5-7</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>John Paul Nor...</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br><b>5/7/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>05/12/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW MEM. PK.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>              |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>MARSHALL W. JONES, JR.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                           |  |  |  |
| 4101 EDMONDSON AVE., BALTO., Md. 21229  |  |   |  |   |  |  |  |  |  |

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**IMPORTANT:** If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 8413557   |  |  |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|-----------------------------------|--|-----------------------|--|-------------------------------|--|----------------------------|--|--------------------------------------|--|
| 1. DECEASED NAME   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                                       |  | 2b. HOUR                                     |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE   |  | 5. DATE OF BIRTH                             |  | 6. AGE                            |  | 7. BIRTHPLACE         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION                        |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                       |  |                               |  |                            |  |                                      |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                            |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS   |  |                               |  |                            |  |                                      |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |  | 16b. SOCIAL SECURITY NO.          |  | 17. INFORMANT         |  | 17b. ADDRESS                  |  |                            |  |                                      |  |
| 18. CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | 19. OTHER SIGNIFICANT CONDITIONS                        |  | 20a. AUTOPSY?                                |  | 20b. IF YES, WERE FINDINGS USED   |  |                       |  |                               |  |                            |  |                                      |  |
| 21. ACCIDENT WAS UNDERLYING  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED                     |  | 21d. INJURY OCCURRED              |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION                 |  |                            |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED                             |  | 22d. PHYSICIAN'S NAME             |  | 22e. ADDRESS          |  | 22f. DATE REC'D. BY REGISTRAR |  | 22g. REGISTRAR'S SIGNATURE |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  |  |  |  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY           |  | 23d. LOCATION                     |  | 23e. COUNTY           |  | 23f. STATE                    |  |                            |  |                                      |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR                            |  | 25b. REGISTRAR'S SIGNATURE                   |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
| HERBERT L. WINTER  |  |  |  |  |  |  |  |  |  | MAY 14 1984   |  |  |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
| MALE   |  |  |  |  |  |  |  |  |  | WHITE   |  | 1 14 1916                                    |  | 68 YRS.                           |  | PENN.                 |  | USA.                          |  | MARRIED                    |  | BALTO CITY                           |  |
| BALTO  |  |  |  |  |  |  |  |  |  | BALTO CITY HOSP.  |  | BETH STEEL                                   |  | STEEL                             |  |                       |  |                               |  |                            |  |                                      |  |
| MD   |  |  |  |  |  |  |  |  |  | BALTO   |  | DUNDALK                                      |  | YES                               |  | 7051 DUNBAR RD. 21222 |  |                               |  |                            |  |                                      |  |
| GEORGE W. WINTER   |  |  |  |  |  |  |  |  |  | MABEL L. DENNY  |  |  |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
| NO   |  |  |  |  |  |  |  |  |  | 213-07-2061   |  | JUANITA WINTER                               |  | 7051 DUNBAR RD.                   |  |                       |  |                               |  |                            |  |                                      |  |
| 4100   |  |  |  |  |  |  |  |  |  | Cardiomyopathy with acute Myocardial infarction         |  |  |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: |  |  |  |  |  |  |  |  |  |   |  |  |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?                                |  | 20b. IF YES, WERE FINDINGS USED   |  |                       |  |                               |  |                            |  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED                     |  | 21d. INJURY OCCURRED              |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION                 |  |                            |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED                             |  | 22d. PHYSICIAN'S NAME             |  | 22e. ADDRESS          |  | 22f. DATE REC'D. BY REGISTRAR |  | 22g. REGISTRAR'S SIGNATURE |  |                                      |  |
| BURIAL   |  |  |  |  |  |  |  |  |  | 5/16/84   |  | OAK LAWN                                     |  | BALTO                             |  | MD.                   |  |                               |  |                            |  |                                      |  |
| CONNELLY FUNERAL HOME OF DUNDALK   |  |  |  |  |  |  |  |  |  | MAY 22 1984   |  | Julia Davidson-Randall                       |  |                                   |  |                       |  |                               |  |                            |  |                                      |  |

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CHIEFMAN

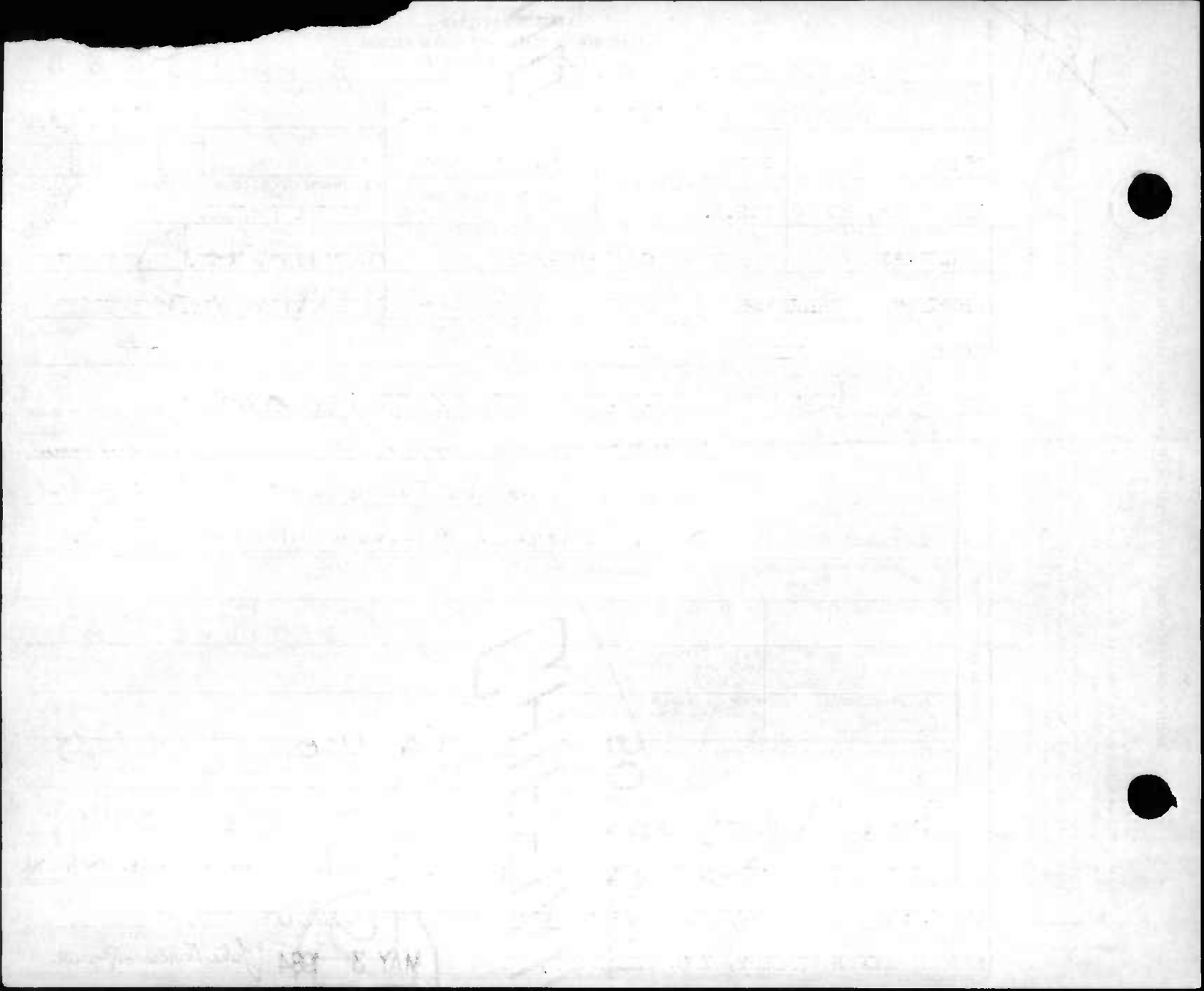


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <b>MELVIN MILLARD WISE, SR.</b>  |  |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MELVIN MILLARD WISE, SR.</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>05 01 84</b>   |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  |  |  |  | 4. RACE<br><b>WHITE</b>   |  |  |  |   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 27 1937</b>  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD</b>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD</b>   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITALS</b> |  |  |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SHEET METAL MECH.</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>  |  |  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  |  | 13b. STREET ADDRESS<br><b>1813 MERRITT BOULEVARD 21222</b>  |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>LOUIS ALLEN WISE</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNA JUBB</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO YES</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216.34.5135</b>  |  |  |  |   |  |
| 17. INFORMANT<br><b>JOAN ANN WISE (same as 13e)</b>   |  |  |  |  | ADDRESS   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Recurrent Ventricular Tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Infective Myocardial Infection</b>                            |  |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION   |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1</b> , 19 <b>84</b> , to <b>May 1</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>May 1</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Bruce Waldholtz MD</b>   |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/1/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRUCE WALDHOLTZ</b>   |  |  | 22e. ADDRESS<br><b>Baltimore City Hospital 4440 Eastern Ave. Baltimore</b> |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  |  | 23b. DATE<br><b>5/4/1984</b>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY, MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER BROOKS BRADLEY, INC., BALTIMORE, MD</b>   |  |  | ADDRESS  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 3 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

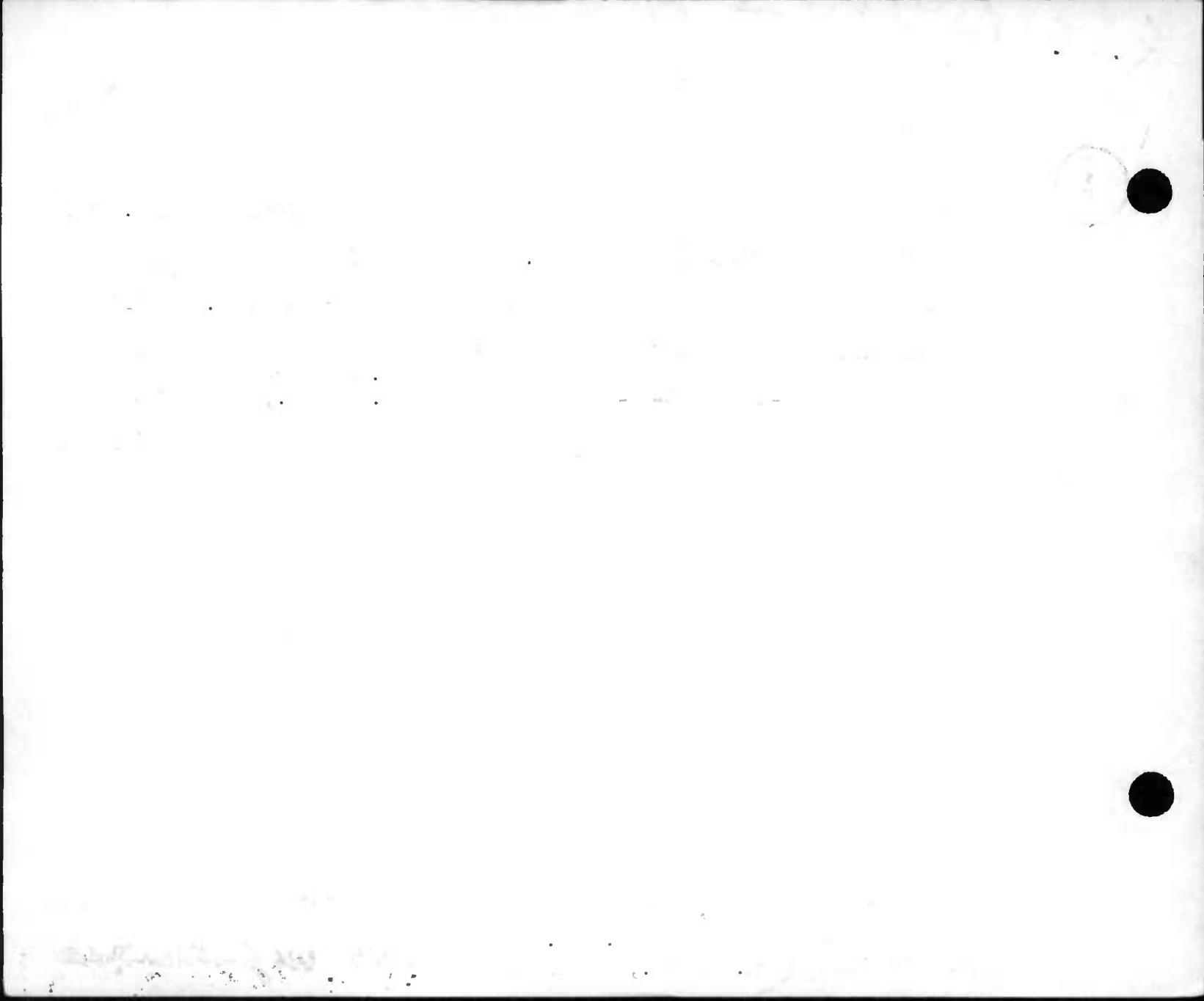
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and see.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8413559

|  |         |  |  |  |      |   |          |
|--|---------|--|--|--|------|---|----------|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH  |  | MONTH  | DAY  | YEAR  | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   | LAST |   |          |
| Berthold   |         | Wolff  |  |  |      | 5 31 1984 3:30 PM   |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |      | 7. IF UNDER 1 YEAR  |          |
| Male   | White   | MONTH DAY YEAR   |  | 77 yrs. YRS.   |      | MONTHS DAYS HOURS MIN.  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH  |          |
| GERMANY  |         | USA  |  |  |      | BALTO. CITY MD.   |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |      | 12b. KIND OF BUSINESS OR INDUSTRY   |          |
| BALTIMORE  |         | GOOD SAMARITAN HOSP.   |  | SALESMAN   |      | CLOTHING  |          |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |          |
| MARYLAND   |         |  |  | BALTIMORE  |      | 13e. STREET ADDRESS / ZIP CODE  |          |
|  |         |  |  |  |      | 3705 MENLO DR. #21215   |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |      | 16b. SOCIAL SECURITY NO.  |          |
| FIRST MIDDLE LAST  |         | FIRST MIDDLE LAST  |  | YES NO   |      | 17. INFORMANT   |          |
| MICHAEL WOLFF  |         | AGATHA HERRMANN  |  |  |      | MRS. KATE WOLFF   |          |
|  |         |  |  |  |      | 3705 MENLO DR. BALTO., MD 21215   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |      |   |          |
| IMMEDIATE CAUSE (a) 4100   |         | Cardiogenic Shock  |  | 24 hrs   |      |   |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         | (b) Acute myocardial infarction  |  |  |      |   |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         | (c)  |  |  |      |   |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |         |  |  |  |      |   |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |      |   |          |
|  |         | P.M. 19  |  |  |      |   |          |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |      |   |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |  |  |      |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4/84 19 to 5/31/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |  |  |      |   |          |
| 22b. SIGNATURE   |         | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |      | 22c. DATE SIGNED  |          |
| Jyoti Parikh MD  |         | Intern   |  |  |      | 5/31/84   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22e. ADDRESS   |  |  |      |   |          |
| JYOTI PARIKH   |         | Good Samaritan Hospital  |  |  |      |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION   |          |
| BURIAL   |         | JUNE 3, 1984   |  | ANSHE EMUNAH   |      | BALTIMORE MARYLAND  |          |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |      |   |          |
| NAME SOL LEVINSON & BROS., INC.  |         | ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |  | JUN 6 1984   |      | John Levinson-Rodriguez   |          |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |   |  |
|--|--|---|--|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH C. WONSOWICH</b>   |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>5 24 84</b>                        |   |  |   |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>6 15 17</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                  |  | 2b HOUR<br><b>145</b> M   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ins. Clerk</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>I.N.A.</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>  |  |   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Arbutus</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leon Wonsowich</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anastasia Butkus</b> |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17 INFORMANT<br><b>Viola Hoffman</b>   |  | ADDRESS<br><b>29 Locust Drive 21228</b>   |  |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>5751</b> IMMEDIATE CAUSE (a) <b>PULMONARY THROMBOEMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>THROMBI, DEEP LEG VEIN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>NUTRITIONAL CIRRHOSIS</b>   |  |   |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>5/5/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CHOLECYSTITIS</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael E. Pelczar</b>   |  |   |  |  | DEGREE<br><b>M</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/25/84</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  |  | 23b. DATE<br><b>5/28/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |   |  |





#1, FilmG591 5/23/84 kam

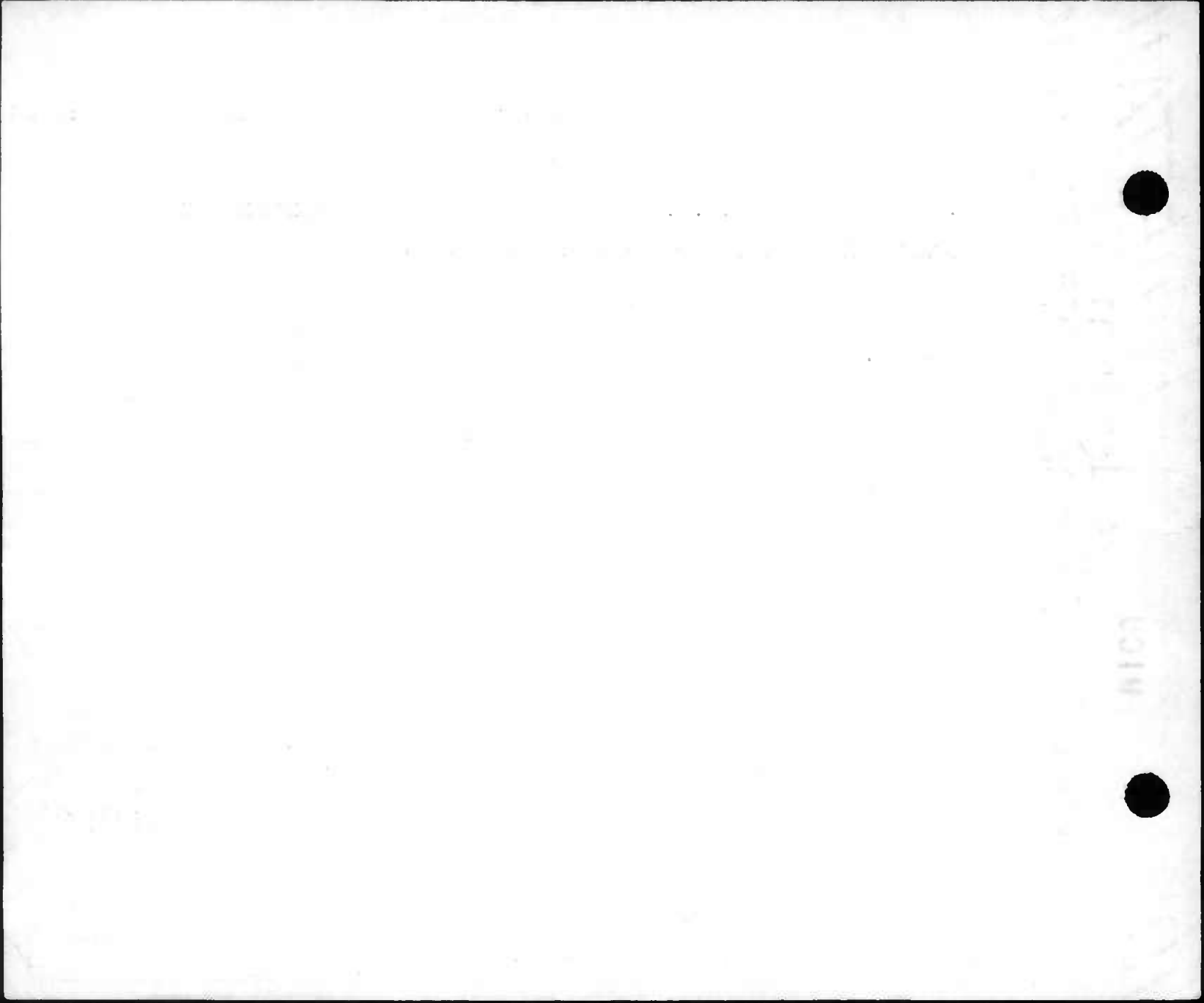
STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>BETTY AKA WOODARD   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05 17 84   |  | 2b. HOUR<br>3:45PM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 54   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>29 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE SITE OF DEATH)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Bell  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellen Woodard   |  | 13e. STREET ADDRESS / ZIP CODE<br>1710 Freedom Way North 21213  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>Margaret Foster  |  | ADDRESS<br>2228 E. Oliver Street   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CEREBRAL EDEMA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) SEPSIS - CEREBRAL BLEEDING |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>0  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 11, 19 84, to MAY 17, 19 84, that (I) (we) lost saw the deceased alive on MAY 17, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Kern Bonham  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/17/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>5/22/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery Baltimore, Md.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br>MAY 18 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>a Davidson-Randall   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8413562<br>REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William F. Woodward.</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 21, 1984</b>   |  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Male.</b>   |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 20, 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Health Services Inc.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Marking D Delop.</b>     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13e. STREET ADDRESS<br><b>3331 Chestnut Ave.</b>                                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William F Woodward Sr.</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle ?</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>Korea.</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs Lorri Custodio 39 Glendale Ave 21061</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 ACUTE MYOCARDIAL INFARCTION</b><br>IMMEDIATE CAUSE (a):<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>INSTANT</b><br><b>YRS</b> |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHF</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-19</b> , 19 <b>84</b> , to <b>4-13</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>4-13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did/did not touch the body after death.)   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Nathan Rosenblum</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>22 MAY 84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NATHAN ROSENBLUM</b>   |  |   |  |   | 22e. ADDRESS<br><b>7600 OSLER DRIVE 21204</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial.</b>  |  | 23b. DATE<br><b>May 23, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Paul E. Chenoweth 3615-19 Chestnut Ave.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>  |  |  |

1941, 12, 10

William F. Woodward

10

1941, 12, 10

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1941, 12, 10

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1941, 12, 10

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1941, 12, 10

1941, 12, 10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RE-EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |   |  |   |  |   |  | REG. NO. 6 3 5 6 3   |  |   |  |
|--|--|--------------|--|---|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |              |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ralph Wright   |  |              |  |   |  |   |  |   |  | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>5-3 1984 |  | 2b. HOUR M<br>10:30 P. M.                   |  |
| 3. SEX<br>M  |  | 4. RACE<br>B |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 29 24  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.                   |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NC  |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital - DOA |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>MD   |  |              |  | 13b. COUNTY<br>Baltimore  |  |   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3000 Spaulding Ave. 21215   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Wright   |  |              |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Daisey      |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |              |  | 16b. SOCIAL SECURITY NO.<br>243-24-8907   |  |   |  | 17. INFORMANT ADDRESS<br>Halique Wright 3000 Spaulding Avenue   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>429.2 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |              |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |              |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |              |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.  |  |              |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | DATE SIGNED<br>5-4-84   |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |              |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |              |  | 23b. DATE<br>5/9/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. National Mem Pk |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Laurel, Md.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H Inc.   |  |              |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>MAY 8 1984                |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson |  |
| ADDRESS<br>1101 E North Avenue   |  |              |  |   |  |   |  |   |  |  |  |   |  |



George Washington 1799 3 JAN

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 84 13564   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Charles B. Wunder   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 17 84   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 27 1900   |  | 2b. HOUR<br>12 45 P.M.  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>83  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  | 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF FACILITY AND STREET ADDRESS)<br>Jennings Memorial Home<br>1000 S. Caton Ave. 21229  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk  |  |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Baltimore Transit   |  |   |  | 13a. STREET ADDRESS<br>1108 Circle Drive 21227  |  |   |  |
| 13b. COUNTY<br>Baltimore   |  |   |  | 13c. CITY OR TOWN<br>Arbutus  |  |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS<br>1108 Circle Drive 21227  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Wunder   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Albert   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-05-9904   |  |   |  |
| 17. INFORMANT ADDRESS<br>C. Lucille Wunder 1108 Circle Dr. 21227   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4360 IMMEDIATE CAUSE (a) Cardio Pulmonary arrest<br>(b) CVA - R. N. M. P. L. S. -><br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-20-81, 19, to 11-17-84, 19, that (I) (we) last saw the deceased alive on 11-17-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>George Anzor   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5-17-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE ANZOR  |  |   |  | 22e. ADDRESS<br>3350. Wilkens Dr. Balt  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5/21/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR (NAME)<br>Hubbard Funeral Home, Inc.  |  |   |  | 24b. ADDRESS<br>4107 Wilkens Ave. 21229   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 18 1984  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |   |  |   |  |

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8413565  
REG. NO.

|  |  |  |  |   |                                     |  |
|--|--|--|--|---|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Madge L Yazvac</b>    |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05/27/84</b>                   |   | 2b. HOUR<br><b>8:17P</b>            |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 18 1917</b>  |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |                                     |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |                                     |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Dundalk</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter S. Keister</b>                   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leona L. Butcher</b> |   |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>    |  | 16b. SOCIAL SECURITY NO.<br><b>215-24-3903</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Thomas H. Yazvac Same as 13e</b>   |                                     |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b><br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5min.</b><br><b>1yr.</b> |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/27/84</b> , 19____, to <b>5/27/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>5/27/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R. Davis M.D.</b>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>5/27/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Resinald Davis</b>   |  |  |  | 22e. ADDRESS<br><b>JHA - 601 N. Wolfe ST</b>   |  |  |  |

|  |  |                               |  |  |  |   |  |
|--|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                      |  | 23b. DATE<br><b>5/31/1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Duda-Ruck</b>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 REG. NO. 13566

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1- FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Albert Francis Yeager, III  |   | MONTH DAY YEAR<br>5 4 84  |  | M   |  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 20 1936   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lever Bros.               |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Dundalk   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Albert F. Yeager, Jr.  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Irene M. Roeder   |  | 13e. STREET ADDRESS / ZIP CODE<br>7836 Kentley Road 21222                                       |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>219-32-8942   |  | 17. INFORMANT ADDRESS<br>Mary A. Yeager Same as 13e   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Seconds</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/4/84</u> 19 <u>83</u> to <u>5/4</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/4/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>D.W. MacDonald</u>   |   | DEGREE<br><u>M.D.</u>   |  | 22c. DATE SIGNED<br><u>5/5/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D.W. MacDonald M.D.  |   | 22e. ADDRESS<br>95. HIGHLAND AVE BALTO MD 21224   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>5/8/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Ht. Of Jesus                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.   |   | 24b. ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 7 1984   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk Baltimore MD.   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH84 13567  
REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |   | A M  |  |
| NICK E YENGICH   |  | MAY 1, 1984  |   | 9:00 A   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS (LAST BIRTHDAY))                             | IF UNDER 1 YEAR  | IF UNDER 24 HRS                              |
| Male   | White  | MONTH DAY YEAR   | 37  | MONTHS DAYS  | HOURS MIN.                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Utah   | U.S.A.   |  | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE  | THE JOHNS HOPKINS HOSPITAL   |  | Reporter  |  | Newspaper                                    |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   |  |
| Maryland   |  | N/A  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | 13e. STREET ADDRESS / ZIP CODE   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   | 212 E. Montgomery St. 21230  |  |
| Nick A. Yengich  |  | Erma Sponga  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
| No.  |  | 529-62-0749  |   | Karen L. Yengich same as #13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> 5728  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic failure</u>  |  |  |   |  | Approx 5-10 min.                             |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5-1</u> 19 <u>84</u> , to <u>5-1</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>5-1</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |   | 22c. DATE SIGNED   |  |
| Joseph S. Weinstein  |  |  |   | 5-1-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   | 22e. ADDRESS   |  |
| Joseph S. Weinstein  |  |  |   | 600 N. WOLFE STREET BALTO, MD 21205  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Cremation  |  | 5/2/84   |   | Balto. Wash. Crematory   |  |
| 24. FUNERAL DIRECTOR   |  | 23d. LOCATION  |   | 23e. DATE REC'D. BY REGISTRAR  |  |
| FLECK FUNERAL HOME, INC.   |  | Laurel, P.G. Co. Md.   |   | MAY 3 1984   |  |
| 7601 Sandy Spring Rd. Laurel, Md. 20707  |  | 23f. REGISTRAR'S SIGNATURE   |   | Davidson-Randall   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

2010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 working days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8413568   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Albert E Yingling Jr   |  |   |  | May 5 1984   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 11 38  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>45  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auto Worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>General Motors   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13. STREET ADDRESS / ZIP CODE  |  |   |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 3434 Leventon Ave 21224   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Albert E Yingling Jr  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Williams   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN   |  | 16b. SOCIAL SECURITY NO.<br>219 26 4611   |  | 17. INFORMANT<br>Smolen Yingling   |  | ADDRESS<br>Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepato Renal Syndrome<br>5712<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) Alcohol Cirrhosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk<br>2 yrs |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Coronary Artery Disease SP Coronary Artery Bypass  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>12/83  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Coronary Artery Disease   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 2/84 to 5/5 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death, so state.)  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Richard A Baumann  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>5/5/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard A Baumann MD  |  |   |  | 22e. ADDRESS<br>Rt 133W148 Univ of Md Hosp   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5-8-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus Bkto.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md   |  |
| 24. FUNERAL DIRECTOR NAME<br>Joseph N. ZANNINO JR  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |

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Handwritten notes, possibly a list or ledger, with various entries and some numbers.

Handwritten notes, possibly a list or ledger, with various entries and some numbers.

Handwritten notes, possibly a list or ledger, with various entries and some numbers.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | 84 REG. NO. 13569  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ALICE B. YON  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 20 1984  |   |  | 2b. HOUR MIN.<br>12:00 P.M.   |  |
| 3. SEX<br>F.  |  | 4. RACE<br>B  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 11 28  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>56 YRS.                            |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. STREET ADDRESS<br>21213 2518 E HOFFMAN ST.                                   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Bailey   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Cora Allen                                     |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Unknown  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>242249119  |   | 17. INFORMANT ADDRESS<br>Joseph Bailey, Sr. Willow Springs, N.C. 27592   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) Metastatic Breast Cancer<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 years |  |   |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1984, to May 20 1984, that (I) (we) lost saw the deceased alive on May 20 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Philip Kmetz  |  |   |   |   | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>5/24/84                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Philip Kmetz   |  |   |   |   | 22e. ADDRESS   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   | 23b. DATE<br>5/23/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Washington National                                    |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suetland, Md.   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H Inc.  |  |   |   |   | ADDRESS<br>1101 E North Avenue   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |

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CLARK & MCKIN

2029 COLLEGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 16

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 3 5 7 0

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret C. Young   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 20, 1984                         |  | 2b. HOUR<br>-6:20A.<br>M.  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 9, 1903   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City<br>MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bal Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cashier | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail Sales                                    |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>21214  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gilbert Proctor  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Howard           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>215-24-0764   |   | 17. INFORMANT<br>ADDRESS<br>20708<br>Daniel R. Young8475 SnowdenOakPlace             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Multiple Organ Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Pneumonia |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Renal Failure, Intra-Abdominal Sepsis   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 11, 19 84, to May 20, 19 84, that (I) (we) last saw the deceased alive on May 20, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>Mark E. Richards M.D.  |  |   |   | 22c. DATE SIGNED<br>May 20, 1984   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mark E. Richards, M.D.  |  |   |   | 22e. ADDRESS<br>C/O Maryland General Hospital  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 22, '84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., MD  |  | 23e. DATE REC'D. BY REGISTRAR<br>MAY 21 1984  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson   |  |   |   | 25. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                  |  |

May 30 1964

Washington, D.C.

May 29, 1964

Mr. William French Smith

Director, FBI

Washington, D.C.

Dear Sir:

Reference is made to your letter of May 27, 1964, regarding the above captioned matter.

Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to you for your information and for your use in the event you wish to take any action.

Very truly yours,

John Edgar Hoover, Director

Enclosure

Very truly yours,

John Edgar Hoover

Special Agent in Charge, Washington Field Office

May 29 1964

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May 29 1964

Washington Field Office

Enclosure

Washington, D.C.

May 29, 1964

Enclosure

Washington, D.C.

May 29, 1964

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

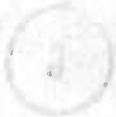
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |                              |  |  |
|--|--|--|--|--|--|---|------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |   |                              |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Violet Young</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 1 84</b>                 |   | 2b. HOUR<br><b>6:30 A.M.</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 27 32</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.   |                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>901 Lynnhurst Street</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |                              |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS / ZIP CODE<br><b>901 Lynnhurst St. 21229</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. Smith</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Johnson</b> |   |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS<br><b>Wesley Young 901 Lynnhurst St.</b>  |  |   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749 IMMEDIATE CAUSE (a) BREAST CARCINOMA</b>   |  |  |  |  |  |   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MONTHS</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |  |  |  |  |   |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 8</b> , 19 <b>83</b> , to <b>MAY 1</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>APRIL 25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |                              |  |  |
| 22b. SIGNATURE<br><b>Paul E. Gormley</b>   |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |                              | 22c. DATE SIGNED<br><b>5/1/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL E. GORMLEY</b>  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTO MD 21229</b>   |  |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/5/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus MemorialPk</b>  |  | 23d. LOCATION<br><b>Arbutus,</b> COUNTY <b>Md.</b> STATE  |                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b> ADDRESS<br><b>1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 2 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |                              |  |  |

LIBER



1944

1944

Items 16a 6/12/84 mtb F#592

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 4 1 3 5 7 2

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Michael A Zak  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05/13/84   |  | 2b. HOUR<br>2:05P  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 25, 1962  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>21  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wisconsin  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Avionics                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>Engineering                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY<br>Virginia Fairfax   |   | 13c. CITY OR TOWN<br>Springfield  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>7113 Rolling Forest Avenue 91999                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ronald Zak  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith Caldwell   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes 1961-83   |   | 16b. SOCIAL SECURITY NO.<br>227-08-2273   | 17. INFORMANT<br>ADDRESS<br>Parents - same as #13a-e  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4589 IMMEDIATE CAUSE (a) Cardiac standstill<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Hypotension<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hours |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>Acute Myelogenous Leukemia, BONE MARROW TRANSPLANT, GRAFT VS HOST DISEASE   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12, 19 84, to 5/13, 19 84, that (I) (we) last saw the deceased alive on 5/13, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br>DREW PARDOLL MD   |   |   |   | 22c. DATE SIGNED<br>5/13/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DREW PARDOLL   |   |   |   | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>5/17/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fairfax Memorial Park                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Fairfax Virginia   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Demaine Funeral Homes, Inc Alexandria, VA   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 20 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>i  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. 100 9 1 YAM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, rows any injury, or other traumatic event, the medical examiner must be notified promptly.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

84 13573

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mildred Katherine Zelinka  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 11 84   |  | 2b. HOUR<br>5:25 AM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 6 08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. Gen. Hosp.  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nicholas Heck   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie Baker   |  | 13e. STREET ADDRESS<br>8803 Parlo Rd, 21236   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>214-22-1126   |  | 17. INFORMANT<br>Loretta Dembinsky, dghtr, 8803 Parlo Rd,   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4860 IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dehydration, mitral regurgitation</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/9</u> 19 <u>84</u> , to <u>5/11</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5/11</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Donna St. Martin  |  | DEGREE  |  | 22c. DATE SIGNED<br>5/11/84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donna St. Martin   |  | 22e. ADDRESS<br>Mercy Hosp Balt MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/14/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHIMUNEK   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 11 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

20% COTTON

CHIEFLIN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 5 7 4  
REG. NO.

|   |  |   |  |   |   |  |   |   |  |  |
|---|--|---|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Richard H.G. Zentgraf</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 20, 1984</b>             |   |   | 2b. HOUR<br>M<br><b>9</b>  |   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-11-1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>79</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5921 Leith Walk</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Brewery Worker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>5921 Leith Walk 21239</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Desch</b> |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-05-4113</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Anna Margaret Zentgraf - 5921 Leith Walk 21239</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>Ischemic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diabetes mellitus</b>  |  |   |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1/25/54</b> to <b>5/20/84</b> , that (I) (we) last saw the deceased alive on <b>4/9/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the noted date and from the noted cause above, (I) (we) (did) (did not) view the body after death. <b>good condition - 4 1/2 hrs to 5 1/2 hrs</b> |  |   |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Thomas L. Worsley</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/21/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS L. WORSLEY M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>6505 YORK Rd - Balto Md 21212</b>  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-23-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>   |  |   |  | 25. DAY REC'D. BY REGISTRAR (25a. REGISTRAR'S SIGNATURE)<br><b>MAY 22 1984</b> <b>John C. Miller</b>  |   |  |   |   |  |  |

BP



Richard H. C. Landon

July 20, 1964

White

Male

6-11-1964

PT

U.S.A.

Balto. Md.

Baltimore City

2921 Leith Walk

Balto. Md.

Barnes Order

Balto.

M.

2921 Leith Walk 21539

Forwarded Check

Unknown

215-07-113

No

215-07-113 - 2921 Leith Walk

Balto. Md.

Forwarded Memorial Book

7-23-64

Burial

John C. Miller Inc. 7115 Belvoir Rd. - 21206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 13575   |  |                               |  |
|--|--|---|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>MILDRED O. ZYLANZ  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/5/84  |  |  |  | 2b. HOUR<br>1247 P.M.         |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 17 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                               |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1524 N. GILMORE ST. 21216  |  |                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES C. BROOK  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>REBECCA OWENS   |  |   |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 16c. ADDRESS<br>21216<br>ANGELIQUE JOHNSON 1524 N. GILMORE ST.                                  |  |  |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4360 CARDIOPULMONARY ARREST.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CERE BRO VASCULAR ACCIDENT<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                   |  |   |  |   |  |   |  |  |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/5 19 84, to 5/5 19 84; that (I) (we) last saw the deceased alive on 5/5 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |                               |  |
| 22b. SIGNATURE<br>Alberici   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED   |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. UBEROI   |  |   |  | 22e. ADDRESS<br>PROVIDENT HOSP. 2600 LIBERTY HTS.   |  |   |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>5/10/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MARYLAND NATIONAL   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>LAUREL, MARYLAND                                  |  |  |  |                               |  |
| 24. FUNERAL DIRECTOR NAME<br>R. Bailey   |  |   |  | 24a. ADDRESS<br>1344 Albemarle St   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |  |                               |  |

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